State: *Colorado* ***Filing Company:*** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Filing at a Glance

Company:	Humana Health Plan Inc.
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO
State:	Colorado
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005C Individual - Other
Filing Type:	Rate
Date Submitted:	05/15/2013
SERFF Tr Num:	HUMA-129026181
SERFF Status:	Closed-Filed
State Tr Num:	278044
State Status:	Filed
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Emma Erickson
Reviewer(s):	Cathy Gilliland (primary), Nichole Boggess, Michael Muldoon, Amy Filler, Rachel Plummer
Disposition Date:	08/12/2013
Disposition Status:	Filed
Implementation Date:	01/01/2014

State Filing Description:
SERFF Binder Filing: HUMA-CO14-125001039-state codes 645-850

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Nicholas Mueller

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 08/12/2013
State Status Changed: 08/02/2013
Created By: Emma Erickson
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: CO-71129 will be offered both on and off exchange. CO-71130-POS will be offered off exchange only.

Filing Description:

Dear Sir or Madam,

We respectfully submit for your review the enclosed premium rates for use with the above captioned policy series. See the actuarial memorandum for more information about this filing.

If you have any questions regarding this filing, please contact me by phone at 920.337.8573 or by email at eerickson@humana.com.

Sincerely,

Emma Erickson
Actuarial Analyst
Individual Product Segment

State Narrative:

State Tracking #278044 Company: Humana Health Plan Product Line: Individual HMO Rate Change Summary
Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014 This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing. The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). On Exchange Only Plans Platinum: 1 plan Gold: 1 plan Silver: 2 plans Bronze: 2 plans Catastrophic: 1 plan
Off Exchange Only Plans Platinum: 1 plan Gold: 1 plan Silver: 4 plans Bronze: 4 plans Catastrophic: 2 plans

Company and Contact

Filing Contact Information

Emma Streubel, Actuarial Analyst
1100 Employers Blvd
Green Bay, WI 54344

estreubel@humana.com
920-337-8573 [Phone]
920-860-1218 [FAX]

State: *Colorado* ***Filing Company:*** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Filing Company Information

Humana Health Plan Inc.	CoCode: 95885	State of Domicile: Kentucky
321 West Main Street	Group Code: 119	Company Type: HMO
Louisville, KY 40202	Group Name:	State ID Number: CO
(800) 558-4444 ext. [Phone]	FEIN Number: 61-1013183	

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

State Specific

Please enter state-specific code(s) found in Colorado's Filing Requirements Bulletins, or on the General Instructions page. Please list all applicable state-specific codes. If no codes are applicable, please enter N/A.: N/A
All rate and loss cost filing types MUST be submitted with completed Rate Data Fields in accordance with Sections 10-4-401 and 10-16-107 C.R.S. This requirement does not apply to form filing types. Rate and loss cost filings not including this data will be rejected. If this is a rate or loss cost filing, have these fields been completed?: Yes
Have you completed the Forms Schedule Tab? ALL Life, Accident, and Health Rate and Form filing types require the Form Schedule Tab to be completed. In addition, all Form, Annual Form Certification, and Refund Calculation filing types require the Form Schedule Tab to be completed. The actual form must be attached to Form filing types only when filing: Medicare Supplement, Long-Term Care Partnership, Stop Loss, P&C Summary Disclosure Forms, and Workers Compensation. It is not necessary to submit the actual form for other lines of insurance. Thank you.: Yes - Rate Filing

SERFF Tracking #: HUMA-129026181 **State Tracking #:** 278044 **Company Tracking #:**

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Nichole Boggess	08/12/2013	08/12/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Michael Muldoon	07/29/2013	07/29/2013
Pending Industry Response	Rachel Plummer	07/05/2013	07/05/2013
Pending Industry Response	Rachel Plummer	07/02/2013	07/02/2013
Pending Industry Response	Rachel Plummer	06/14/2013	06/14/2013
Pending Industry Response	Cathy Gilliland	06/13/2013	06/13/2013
Pending Industry Response	Rachel Plummer	06/06/2013	06/06/2013
Pending Industry Response	Cathy Gilliland	06/05/2013	06/05/2013

Response Letters

Responded By	Created On	Date Submitted
Emma Erickson	07/29/2013	07/29/2013
Emma Erickson	07/11/2013	07/11/2013
Emma Erickson	07/09/2013	07/09/2013
Emma Erickson	06/19/2013	06/19/2013
Emma Erickson	06/13/2013	06/13/2013
Emma Erickson	06/06/2013	06/06/2013
Emma Erickson	06/06/2013	06/06/2013

SERFF Tracking #: HUMA-129026181 **State Tracking #:** 278044 **Company Tracking #:**

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Cathy Gilliland	05/29/2013	05/29/2013
Pending Industry Response	Cathy Gilliland	05/22/2013	05/22/2013

Response Letters

Responded By	Created On	Date Submitted
Emma Erickson	06/05/2013	06/05/2013
Emma Erickson	06/05/2013	06/05/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Actuarial Memorandum and Certifications	Emma Erickson	07/17/2013	07/17/2013
Supporting Document	Unified Rate Review Template	Emma Erickson	07/17/2013	07/17/2013
Supporting Document	Geographic Area & Network Factor Build Up	Emma Erickson	07/11/2013	07/11/2013
Supporting Document	Actuarial Memorandum	Emma Erickson	06/19/2013	06/19/2013
Supporting Document	Exhibit B - Trend Exhibits	Emma Erickson	06/19/2013	06/19/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Revised Rate Sample Per Division's Request	Note To Reviewer	Emma Erickson	05/30/2013	05/30/2013
URRT	Note To Filer	Cathy Gilliland	05/23/2013	05/23/2013

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/12/2013
Implementation Date: 01/01/2014
Status: Filed

HHS Status: HHS Approved
State Review: Reviewed by Actuary

Comment: State Tracking #278044
Company: Humana Health Plan
Product Line: Individual HMO

Rate Change Summary
Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).
On Exchange Only Plans
Platinum: 1 plan
Gold: 1 plan
Silver: 2 plans
Bronze: 2 plans
Catastrophic: 1 plan

Off Exchange Only Plans
Platinum: 1 plan
Gold: 1 plan
Silver: 4 plans
Bronze: 4 plans
Catastrophic: 2 plans

Final Rate Filing Disposition
The Division has filed the rates in their final form after all adjustments.

SERFF Tracking #: HUMA-129026181 **State Tracking #:** 278044 **Company Tracking #:**

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

See attached document for more information on this filing.

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Health Plan Inc.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Percent Change Approved:
Minimum: 0.000%
Maximum: 0.000%
Weighted Average: 0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	HR-1 Form (H)		Yes
Supporting Document	Consumer Disclosure Form		Yes
Supporting Document (revised)	Actuarial Memorandum and Certifications		Yes
Supporting Document	Actuarial Memorandum and Certifications		Yes
Supporting Document	Actuarial Memorandum and Certifications		Yes
Supporting Document (revised)	Unified Rate Review Template		Yes
Supporting Document	Unified Rate Review Template		Yes
Supporting Document	Unified Rate Review Template		Yes
Supporting Document	Cover Letter		Yes
Supporting Document (revised)	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes

SERFF Tracking #: HUMA-129026181 **State Tracking #:** 278044 **Company Tracking #:**

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Exhibit A -CO HHP Past & Future Projected Experience		Yes
Supporting Document	Exhibit A -CO HHP Past & Future Projected Experience		Yes
Supporting Document (revised)	Exhibit B - Trend Exhibits		Yes
Supporting Document	Exhibit B - Trend Exhibits		Yes
Supporting Document	Exhibit B - Trend Exhibits		Yes
Supporting Document (revised)	Rate Review Detail		Yes
Supporting Document	Rate Review Detail		Yes
Supporting Document	Rate Review Detail		Yes
Supporting Document (revised)	Rate Sample		Yes
Supporting Document	Rate Sample		Yes
Supporting Document	Benefit Ratio Justification		Yes
Supporting Document	Wellness Program & Rewards		Yes
Supporting Document	Plan & Benefits Template		Yes
Supporting Document	Exhibit C - CO HHP Base Rate Development		Yes
Supporting Document	Geographic Area & Network Factor Build Up		Yes
Form	CO Suite A HMOx		Yes
Form	CO Suite C POS		Yes
Rate (revised)	2014 CO HHP Rate Manual		Yes
Rate	2014 CO HHP Rate Manual		Yes
Rate	2014 CO HHP Rate Manual		Yes

Final Disposition Letter

State Tracking #278044
Company: Humana Health Plan
Product Line: Individual HMO

Rate Change Summary

Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a New ACA Compliant Filing for 2014, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA).

On Exchange Only Plans
Platinum: 1 plan
Gold: 1 plan
Silver: 2 plans
Bronze: 2 plans
Catastrophic: 1 plan

Off Exchange Only Plans
Platinum: 1 plan
Gold: 1 plan
Silver: 4 plans
Bronze: 4 plans
Catastrophic: 2 plans

Rate Methodology

Experience Used for Rate Setting: Utilized the Humana Individual Block of business data for 2012.

2012 Experience Period Loss Ratio: 51.9% based on 91,997 member months. This was a very new highly underwritten block of business still in 2012.

Annual Health Cost Trends: 9.6%

Risk Adjustment: 0% (payments expected from the federal Risk Adjustment Program in 2014).

Reinsurance Recoveries: -11.5% (payments expected from the federal Reinsurance Program in 2014).

Smoking Factor: 10% higher rates for smokers at all ages.

Age Rating: 3.0 to 1.0 age rating factor limits for all adults age 21 and over.

Colorado 2014 Overall Average Premium: $234.94

* Federal Reported 2014 Comparable Average Premium: $234.94

* This is reported on the issuer's CMS URRT Form submitted in HIOS. It represents a standardized average premium calculation that is used by CMS for comparing and gauging premium develpment. It is not necessarily the actual average premium, which is shown in the line above as Colorado 2014 Overall Average Premium.

Premium Retained to Cover Expenses, Taxes Fees and Profits

Administrative costs: Expenses the insurance company pays to operate this insurance plan. This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the company's offices and equipment, commissions to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes.

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.

Premium retention is 25.1% shown as follows:

		% of Premium Retained
	Issuer Primary Expense and Profit Retention	
	Administrative Expenses:	9.60%
	Direct Response, Marketing, & Agency Management:	1.60%
	Commissions:	4.40%
	Profit and Contingencies After Taxes:	3.10%
	Contingencies:	
	Net Private Reinsurance:	
	FIT - Federal Income Taxes:	2.50%
	Investment Income:	
(A)	Total:	21.20%
	Retention for Additional Required Taxes, Fees and Assessments	
	PPACA Health Insurer Fee:	1.40%

	PPACA Reinsurance Fee:	
	PPACA CERF and PCORI Fee:	0.10%
	PPACA Risk Adjustment User Fee:	
	Exchange user fees:	0.90%
	Premium Taxes:	0.30%
	State Income Taxes:	
	Other Fees, Assessments, Taxes:	0.00%
(B)	Total:	2.70%
	Additional Allowed for QI & Member Welfare Section	
	Quality Improvement:	1.20%
	Community Charitable:	
	IT for ICD-10 Conversion (max allowed 0.3%):	
(C)	Total:	1.20%
(D)	Total Premium Retention For All Purposes (A + B + C):	25.10%
(E)	Colorado Conventional Loss Ratio (100% - D):	74.90%
	Federal MLR Loss Ratio Basis: (E + C) / (100% - B - FIT):	80.27%

Sample of Final Premium Levels

			Boulder		Colorado Springs		Denver	
Level of Coverage*	Network Name	Plan Type*	Low	High	Low	High	Low	High
Platinum	Colorado HMOx	HMO			$255.36	$256.40	$264.02	$265.09
Gold	Colorado HMOx	HMO			$226.50	$227.40	$234.18	$235.11
Silver	National POS Open Access	POS	$333.98	$339.84	$275.64	$280.48	$291.29	$296.40
	Colorado HMOx	HMO			$198.58	$202.24	$205.32	$209.10
Bronze	National POS Open Access	POS	$288.86	$324.96	$238.40	$268.20	$251.94	$283.43
	Colorado HMOx	HMO			$175.11	$189.51	$181.05	$195.94
Catastrophic	National POS Open Access	POS	$240.60	$240.60	$198.57	$198.57	$209.85	$209.85
	Colorado HMOx	HMO			$139.14	$139.69	$143.86	$144.43

Division Objections and Rate Changes During the Review Process

The Division objected to Humana adding rates for areas where rates had not initially been filed. Humana indicated the rates were for “movers”, not for new sales.

The Division objected to the large risk adjustment assumption of -8.9% built into the rates. Humana adjusted their actuarial assumptions within the parameters set by the Division.

The Division objected to the number of plans filed in the rate manual not matching the number of plans within the Plans and Benefit Template. Humana revised their filing to match.

The Division objected to 0.3% of retention for fees, and directed Humana to carry as margin.

Final Rate Filing Disposition

The Division has filed the rates in their final form after all adjustments.

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/29/2013
Submitted Date	07/29/2013
Respond By Date	07/29/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

- Actuarial Memorandum and Certifications (Supporting Document)

Comments: You list retention for State Premium tax of 0.3%:

"This category include assessments and fees and is held constant at our Colorado actual level of 0.3% of premium for this legal entity."

Please clarify what this 0.3% is for specifically.
Please note that assessments for CoverColorado are no longer warranted for 2014.

If necessary, you may adjust this out from your premium, or carry it for this period as an additional 0.3% contingency margin.
All rating adjustments should be completed by Monday July 29th in order to allow rates to be sent to the Exchange by July 31st.

Conclusion:

Sincerely,
Michael Muldoon

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/05/2013
Submitted Date	07/05/2013
Respond By Date	07/11/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide a new rate manual in the following format:

*Base Premium = (Age Factor) * (Plan Benefit Factor) * (Network Factor) * (Area Factor) * (Tobacco Factor) * (Any other factors built into the rate)*

Provide a table for each of the following factors listed above.

Also, for the Plan Benefit factors and Network factors, please include the plan id, plan marketing name, metal level and factor.

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 07/11/2013, which is within 6 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 07/11/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Rachel Plummer

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/02/2013
Submitted Date	07/02/2013
Respond By Date	07/09/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: The following plans are listed on the Rate Manual (in the rate filing), but are not listed in the Plans and Benefits Template (in the binder filing):
Humana Connect Bronze 4900/6400 Plan
Humana Preferred Bronze 4900/6400 Plan
Humana Preferred Silver 4250/6250 Plan
Humana Preferred Silver 3650/3650 Plan
Humana Connect Bronze 4900/6400 Plan
Humana Preferred Bronze 4900/6400 Plan

The following plans are listed on the Plans and Benefits Template, but are not listed in the Rate Manual:
74320CO0610003 - Humana Connect Bronze 4850/6350 Plan
74320CO0610010 - Humana Connect Bronze 4850/6350 Plan with Children's Dental
74320CO0620003 - Humana Preferred Bronze 4850/6350 Plan with Children's Dental

Please make the necessary changes so that these match.

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by [DATE], which is within [20] calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by [SAME DATE AS ABOVE].

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Rachel Plummer

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/14/2013
Submitted Date	06/14/2013
Respond By Date	06/19/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide the number of member months in the Requested Rate Change Information on the Rate Review Detail section.

Objection 2

Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/19/2013, which is within 5 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/19/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Rachel Plummer

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/13/2013
Submitted Date	06/13/2013
Respond By Date	06/17/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: objection 15-Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least (3)years. Please provide the 3 previous years experience.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/17/2013, which is within 4 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/17/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/06/2013
Submitted Date	06/06/2013
Respond By Date	06/20/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide the URRT is an .xls file as we are able to download the URRT as a XML doc. We acknowledge that the URRT has been uploaded in your binder filing, but also needs to be uploaded in the Supporting Docs tab of the rate filing in SERFF.

Objection 2

Comments: Please include the "Terminated Products" section of the Part III Actuarial Memorandum under Supporting Documents.
List the name of each product that will be terminated prior to the effective date. Include both products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter. If this section is not applicable, then please specify within. This should be located after the "Membership Projections" section.

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/20/2013, which is within 14 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/20/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Rachel Plummer

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/05/2013
Submitted Date	06/05/2013
Respond By Date	06/07/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: objection 1, Regulation 4-2-11 section 6 (a) PPACA rate filing procedure (A) 5 Please provide: Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB. (Please list all of the policies and a description of all of them and how they differ from one another.)

Conclusion:

If any of the requested rate information results in changes to the filing forms (HR-1 or A, B, C or D), please also submit revised forms.

Sincerely,

Cathy Gilliland

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/29/2013
Submitted Date	05/29/2013
Respond By Date	06/05/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Regulation 4-2-11 section 6 (a) PPACA rate filing procedure (A) 5 Please provide: Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB.

Objection 2

Comments: If any documents are in an excel format, please also provide them as PDF files.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/05/2013, which is within 7 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/05/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/22/2013
Submitted Date	05/22/2013
Respond By Date	06/05/2013

Dear Emma Streubel,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please provide the URRT is a xls doc as we are able to download the URRT as a XML doc.

Objection 2

Comments: Please provide a detailed description of the rate filing on the general information tab.

Objection 3

Comments: Please provide the product name (street name) on the general information tab.

Objection 4

Comments: If this is a new product there would not be prior rate information on the view rate review detail. Please make changes.

Objection 5

Comments: Please provide the Unifed rate template in a xls template. We are not able to open the xlm doc.

Objection 6

- Actuarial Memorandum (Supporting Document)

Comments: Please indicate which of the following PPACA benefits your plan has implemented:
Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

Objection 7

- Actuarial Memorandum (Supporting Document)

Comments: (J) Provisions of profit and contigencies need to be part of (H) retention components. Regulation 4-2-11 section 6 (H) Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

Objection 8

- Actuarial Memorandum (Supporting Document)

Comments: (I) Lifetime loss ratios no longer applies to health benefit plans.

Objection 9

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H)-new Actuarial Memorandum (G) please provide the targeted Loss ratio. Benefits Ratio Guidelines:

a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage.

b. The Division recommended benefit ratio guidelines are as listed below. Targeted loss ratios below these guidelines shall be actuarially justified.

37

Comprehensive Major Medical - Individual

80%

Comprehensive Major Medical - Small Group

80%

Comprehensive Major Medical - Large Group

85%

c.

Objection 10

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (K) Complete explaination as to how the proposed rates were determined. "please see" is not acceptable.

Objection 11

- Actuarial Memorandum (Supporting Document)

Comments: Please see is not acceptable. Regulation 4-2-11 section 6 (L) Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

Objection 12

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (M) please see is not acceptable. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.

2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Objection 13

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Actuarial Memorandum (G) Targeted Loss ratio for Individual is 80%. Please

provide projected premiums and incurred claims.

Objection 14

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 5 (B) Please date Actuarial certification. Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuarys opinion, the rates are not excessive, inadequate or unfairly discriminatory. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10.B and 18.B of Colorado Insurance Regulation 4-4-1).

Objection 15

- Exhibit A -CO HHP Past & Future Projected Experience (Supporting Document)

Comments: regulation 4-2-11 section 6 (N) or actuarial Memorandum rate filing procudure (L) , Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.

1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available.

4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/05/2013, which is within 14 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/05/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/29/2013
Submitted Date	07/29/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

A 0.25% rate was built into the premium tax to cover any miscellaneous regulatory charges and administration of assessments. These would include certificate of authority renewal, costs of compliance with state surveys & regulatory filing fees, among others. We would like to carry this through this years pricing.

Related Objection 1

Applies To:

- Actuarial Memorandum and Certifications (Supporting Document)

Comments: You list retention for State Premium tax of 0.3%:
"This category include assessments and fees and is held constant at our Colorado actual level of 0.3% of premium for this legal entity."

Please clarify what this 0.3% is for specifically.
Please note that assessments for CoverColorado are no longer warranted for 2014.

If necessary, you may adjust this out from your premium, or carry it for this period as an additional 0.3% contingency margin.
All rating adjustments should be completed by Monday July 29th in order to allow rates to be sent to the Exchange by July 31st.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	HUMA-129026181	**State Tracking #:**	278044	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Humana Health Plan Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/11/2013
Submitted Date	07/11/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

A revised rate manual has been uploaded.

Related Objection 1

Comments: Please provide a new rate manual in the following format:

*Base Premium = (Age Factor) * (Plan Benefit Factor) * (Network Factor) * (Area Factor) * (Tobacco Factor) * (Any other factors built into the rate)*

Provide a table for each of the following factors listed above.

Also, for the Plan Benefit factors and Network factors, please include the plan id, plan marketing name, metal level and factor.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking #: *HUMA-129026181* **State Tracking #:** *278044* **Company Tracking #:**

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	2014 CO HHP Rate Manual	CO-71129, CO-71130-POS	New		CO HHP RATE MANUAL 01_01_2014.pdf,	07/11/2013 By: Emma Erickson
Previous Version						
1	*2014 CO HHP Rate Manual*	*CO-71129, CO-71130-POS*	*New*		*CO HHP RATE MANUAL 01_01_2014.pdf,*	*07/09/2013 By: Emma Erickson*
Previous Version						
1	*2014 CO HHP Rate Manual*	*CO-71129, CO-71130-POS*	*New*		*6 - CO HHP Rate Manual 2014_01_01.pdf,*	*05/15/2013 By: Nicholas Mueller*

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	HUMA-129026181	**State Tracking #:**	278044	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Humana Health Plan Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/09/2013
Submitted Date	07/09/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

Attached is a revised rate manual that is consistent with the Plans and Benefits Template submitted in the binder filing. Please note that another Objection from Rachel Plummer, recieved 7/5/2013, is requesting additional modifications to the rate manual. We are currently completing these modifications and plan to submit another revised rate manual in response to this 7/5/2013 objection by its requested due date, 7/11/2013.

Related Objection 1

Comments: The following plans are listed on the Rate Manual (in the rate filing), but are not listed in the Plans and Benefits Template (in the binder filing):
Humana Connect Bronze 4900/6400 Plan
Humana Preferred Bronze 4900/6400 Plan
Humana Preferred Silver 4250/6250 Plan
Humana Preferred Silver 3650/3650 Plan
Humana Connect Bronze 4900/6400 Plan
Humana Preferred Bronze 4900/6400 Plan

The following plans are listed on the Plans and Benefits Template, but are not listed in the Rate Manual:
74320CO0610003 - Humana Connect Bronze 4850/6350 Plan
74320CO0610010 - Humana Connect Bronze 4850/6350 Plan with Children's Dental
74320CO0620003 - Humana Preferred Bronze 4850/6350 Plan with Children's Dental

Please make the necessary changes so that these match.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking #: *HUMA-129026181* **State Tracking #:** *278044* **Company Tracking #:**

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	2014 CO HHP Rate Manual	CO-71129, CO-71130-POS	New		CO HHP RATE MANUAL 01_01_2014.pdf,	07/09/2013 By: Emma Erickson
Previous Version						
1	*2014 CO HHP Rate Manual*	*CO-71129, CO-71130-POS*	*New*		*6 - CO HHP Rate Manual 2014_01_01.pdf,*	*05/15/2013 By: Nicholas Mueller*

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/19/2013
Submitted Date	06/19/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

The Rate Review Detail and Rate Review Detail Supporting Document have been revised and uploaded.

Related Objection 1

Comments: Please provide the number of member months in the Requested Rate Change Information on the Rate Review Detail section.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rate Review Detail
Comments:	
Attachment(s):	5- 2014 Rate-Rule Schedule & Rate Review Detail.pdf
Previous Version	
Satisfied - Item:	*Rate Review Detail*
Comments:	
Attachment(s):	*5- 2014 Rate-Rule Schedule & Rate Review Detail.pdf*
Previous Version	
Satisfied - Item:	*Rate Review Detail*
Comments:	
Attachment(s):	*5 - 2014 Rate Review Detail Supporting Document.pdf*

No Form Schedule items changed.

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

No Rate/Rule Schedule items changed.

Response 2

Comments:

Exhibit C - CO HHP Base Rate Development has been uploaded under the Supporting Documents. This exhibit is referenced in the attached CO Actuarial Memorandum.

Related Objection 2

Comments: Please provide a calculation summary that includes the starting index rate along with all of the components and factors used to reach the final index rate. Be sure to include all adjustments. Please upload an excel and pdf version of this summary.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Exhibit C - CO HHP Base Rate Development
Comments:	
Attachment(s):	Exhibit C - CO HHP Base Rate Development.xlsx Exhibit C CO HHP Base Rate Development.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/13/2013
Submitted Date	06/13/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

This rate filing is for new business only and the products included in this filing were priced using our current non-grandfathered business on the Humana Health Plan legal entity. Individual business began being issued on 10/1/2011 on this legal entity, therefore we are unable to provide three full years of experience.

Related Objection 1

Comments: objection 15-Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least (3)years. Please provide the 3 previous years experience.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

State: *Colorado* **Filing Company:** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/06/2013
Submitted Date	06/06/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

The URRT has been uploaded as an .xlsx file under the Supporting Documents Tab.

Related Objection 1

Comments: Please provide the URRT is an .xls file as we are able to download the URRT as a XML doc. We acknowledge that the URRT has been uploaded in your binder filing, but also needs to be uploaded in the Supporting Docs tab of the rate filing in SERFF.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

A list of terminated products has been added to the attached Part III Actuarial Memorandum.

Related Objection 2

Comments: Please include the "Terminated Products" section of the Part III Actuarial Memorandum under Supporting Documents.
List the name of each product that will be terminated prior to the effective date. Include both products that have experience included in the single risk pool during the experience period and any products that were not in effect during the experience but were made available thereafter. If this section is not applicable, then please specify within. This should be located after the "Membership Projections" section.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/06/2013
Submitted Date	06/06/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

The Plan & Benefits Template has been uploaded in an excel format under the Supporting Documents Tab.

Related Objection 1

Comments: objection 1, Regulation 4-2-11 section 6 (a) PPACA rate filing procedure (A) 5 Please provide: Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB. (Please list all of the policies and a description of all of them and how they differ from one another.)

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	COHMOActuarialMemorandumandExhibitsrevised2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*CO HMO Actuarial Memorandum and Exhibits_revised 2.pdf*

Satisfied - Item:	Plan & Benefits Template
Comments:	
Attachment(s):	H1_SBE_CO_PlansBenefits.xlsx

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	COHMOActuarialMemorandumandExhibitsrevised2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*CO HMO Actuarial Memorandum and Exhibits_revised 2.pdf*

Satisfied - Item:	Plan & Benefits Template
Comments:	
Attachment(s):	H1_SBE_CO_PlansBenefits.xlsx

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	HUMA-129026181	**State Tracking #:**	278044	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Humana Health Plan Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/05/2013
Submitted Date	06/05/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 1

Comments: Regulation 4-2-11 section 6 (a) PPACA rate filing procedure (A) 5 Please provide: Product Descriptions: This section should describe the benefits provided by the policy. Must include EHB and list any substitution of benefits or any additional benefits above the EHB.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

All documents previously provided in excel format have been uploaded in pdf format per your request.

Related Objection 2

Comments: If any documents are in an excel format, please also provide them as PDF files.

Changed Items:

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Exhibit A -CO HHP Past & Future Projected Experience
Comments:	
Attachment(s):	4 - Rate Filing Projection Exhibit 2014_01_01 CO HHP v2.pdf
Previous Version	
Satisfied - Item:	*Exhibit A -CO HHP Past & Future Projected Experience*
Comments:	
Attachment(s):	*3 - Exhibit A - CO HHP Past & Projected Future Experience.xlsx*

Satisfied - Item:	Exhibit B - Trend Exhibits
Comments:	
Attachment(s):	3 - Trend Exhibits.pdf
Previous Version	
Satisfied - Item:	*Exhibit B - Trend Exhibits*
Comments:	
Attachment(s):	*4 - Exhibit B - Trend Exhibits.xlsx*

Satisfied - Item:	Rate Sample
Comments:	
Attachment(s):	7 - CO HHP Rate Sample 2014_01_01.xlsx 7 - State of Colorado - Rate Sample.xlsx 7 - State of Colorado - Rate Sample.pdf
Previous Version	
Satisfied - Item:	*Rate Sample*
Comments:	
Attachment(s):	*7 - CO HHP Rate Sample 2014_01_01.xlsx*

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Exhibit A -CO HHP Past & Future Projected Experience
Comments:	
Attachment(s):	4 - Rate Filing Projection Exhibit 2014_01_01 CO HHP v2.pdf
Previous Version	
Satisfied - Item:	*Exhibit A -CO HHP Past & Future Projected Experience*
Comments:	
Attachment(s):	*3 - Exhibit A - CO HHP Past & Projected Future Experience.xlsx*

Satisfied - Item:	Exhibit B - Trend Exhibits
Comments:	
Attachment(s):	3 - Trend Exhibits.pdf
Previous Version	
Satisfied - Item:	*Exhibit B - Trend Exhibits*
Comments:	
Attachment(s):	*4 - Exhibit B - Trend Exhibits.xlsx*

Satisfied - Item:	Rate Sample
Comments:	
Attachment(s):	7 - CO HHP Rate Sample 2014_01_01.xlsx 7 - State of Colorado - Rate Sample.xlsx 7 - State of Colorado - Rate Sample.pdf
Previous Version	
Satisfied - Item:	*Rate Sample*
Comments:	
Attachment(s):	*7 - CO HHP Rate Sample 2014_01_01.xlsx*

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Exhibit A -CO HHP Past & Future Projected Experience
Comments:	
Attachment(s):	4 - Rate Filing Projection Exhibit 2014_01_01 CO HHP v2.pdf
Previous Version	
Satisfied - Item:	*Exhibit A -CO HHP Past & Future Projected Experience*
Comments:	
Attachment(s):	*3 - Exhibit A - CO HHP Past & Projected Future Experience.xlsx*

Satisfied - Item:	Exhibit B - Trend Exhibits
Comments:	
Attachment(s):	3 - Trend Exhibits.pdf
Previous Version	
Satisfied - Item:	*Exhibit B - Trend Exhibits*
Comments:	
Attachment(s):	*4 - Exhibit B - Trend Exhibits.xlsx*

Satisfied - Item:	Rate Sample
Comments:	
Attachment(s):	7 - CO HHP Rate Sample 2014_01_01.xlsx 7 - State of Colorado - Rate Sample.xlsx 7 - State of Colorado - Rate Sample.pdf
Previous Version	
Satisfied - Item:	*Rate Sample*
Comments:	
Attachment(s):	*7 - CO HHP Rate Sample 2014_01_01.xlsx*

SERFF Tracking #:	HUMA-129026181	**State Tracking #:**	278044	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Humana Health Plan Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO		
Project Name/Number:	/		

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/05/2013
Submitted Date	06/05/2013

Dear Cathy Gilliland,

Introduction:

Response 1

Comments:

The URRT has been uploaded as an xls doc.

Related Objection 1

Comments: Please provide the URRT is a xls doc as we are able to download the URRT as a XML doc.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	H1_SBE_CO_HMO_unified_rate_review.xls
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*UnifiedRateReviewSubmission-CO HMO.xml*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

SERFF will not allow me to edit the Filing Description on the general information tab. For a detailed description of the filing, please see the Actuarial Memorandum.

Related Objection 2

Comments: Please provide a detailed description of the rate filing on the general information tab.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

The product name has been provided on the general information tab.

Related Objection 3

Comments: Please provide the product name (street name) on the general information tab.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

We apologize for any confusion. The rate review detail and rate schedule tabs have been revised to reflect this being a new product.

Related Objection 4

Comments: If this is a new product there would not be prior rate information on the view rate review detail. Please make changes.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rate Review Detail
Comments:	
Attachment(s):	5- 2014 Rate-Rule Schedule & Rate Review Detail.pdf
Previous Version	
Satisfied - Item:	*Rate Review Detail*
Comments:	
Attachment(s):	*5 - 2014 Rate Review Detail Supporting Document.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

The URRT has been uploaded as an xls doc.

Related Objection 5

Comments: Please provide the Unifed rate template in a xls template. We are not able to open the xlm doc.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	H1_SBE_CO_HMO_unified_rate_review.xls
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*UnifiedRateReviewSubmission-CO HMO.xml*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 6

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Please indicate which of the following PPACA benefits your plan has implemented:

Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 7

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: (J) Provisions of profit and contigencies need to be part of (H) retention components. Regulation 4-2-11 section 6 (H) Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 8

Comments:

This section has been removed from the Actuarial Memorandum. The targeted loss ratio/benefits ratio can be found under section O of the Actuarial Memorandum.

Related Objection 8

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: (I) Lifetime loss ratios no longer applies to health benefit plans.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 9

Comments:

We have provided actuarial justification for our targeted benefits ratio under the supporting documents tab pursuant to Regulation 4-2-11 section 6 (H): The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Related Objection 9

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H)-new Actuarial Memorandum (G) please provide the targeted Loss ratio. Benefits Ratio Guidelines:
a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage.
b. The Division recommended benefit ratio guidelines are as listed below. Targeted loss ratios below these guidelines shall be actuarially justified.
37
Comprehensive Major Medical - Individual
80%
Comprehensive Major Medical - Small Group
80%
Comprehensive Major Medical - Large Group
85%
c.

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 10

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 10

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (K) Complete explaination as to how the proposed rates were determined. "please see" is not acceptable.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 11

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 11

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Please see is not acceptable. Regulation 4-2-11 section 6 (L) Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 12

Comments:

A revised Actuarial memorandum has been uploaded under the supporting documents.

Related Objection 12

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (M) please see is not acceptable. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.
1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.
2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 13

Comments:

We have provided actuarial justification for our targeted benefits ratio under the supporting documents tab pursuant to Regulation 4-2-11 section 6 (H): The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Related Objection 13

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Actuarial Memorandum (G) Targeted Loss ratio for Individual is 80%. Please provide projected premiums and incurred claims.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 14

Comments:

The Actuarial certification within the Actuarial memorandum has been signed and dated.

Related Objection 14

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 5 (B) Please date Actuarial certification. Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuarys opinion, the rates are not excessive, inadequate or unfairly discriminatory. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10.B and 18.B of Colorado Insurance Regulation 4-4-1).

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.01).pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 15

Comments:

Our Colorado data is credible; therefore there is no additional experience to provide for this filing.

Related Objection 15

Applies To:

- Exhibit A -CO HHP Past & Future Projected Experience (Supporting Document)

SERFF Tracking #:	HUMA-129026181	**State Tracking #:**	278044	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Humana Health Plan Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other		
Product Name:	HumanaOne Suite A HMOx; HumanaOne Suite C PPO		
Project Name/Number:	/		

Comments: regulation 4-2-11 section 6 (N) or actuarial Memorandum rate filing procudure (L) , Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.

1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall also be provided in order to support the rates, if the Colorado data is not fully credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

3. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available.

4. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Emma Erickson

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 07/17/2013

Comments:

During our July 2nd phone conference with the CO DOI, the following was requested,

1) CO HHP Rate Filing – lower our current risk adjustment (-8.3%) to be in the range of +/- 5%.

2) CO HIC Rate Filing – provide an explanation for the 15.9% risk adjustment. (See HUMA-129031275)

The URRT & Actuarial Memorandum have been revised accordingly and uploaded under the Supporting Documents tab.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	COHMOActuarialMemorandumandExhibitsrevised3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*COHMOActuarialMemorandumandExhibitsrevised2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*CO HMO Actuarial Memorandum and Exhibits_revised 2.pdf*

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	H1_SBE_CO_HMO_unified_rate_review fix.xls
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*H1_SBE_CO_HMO_unified_rate_review.xls*
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*UnifiedRateReviewSubmission-CO HMO.xml*

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 07/11/2013

Comments:

As requested by the Division of Insurance during our phone conference, 7/2/2013, we have uploaded an exhibit, under the Supporting Documents tab, that demonstrates our geographic area and network factor build up.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes	
Satisfied - Item:	Geographic Area & Network Factor Build Up
Comments:	
Attachment(s):	CO GeoNet Build-Up 2014.01.01.pdf

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 06/19/2013

Comments:

Per our phone conversation with Michael Muldoon on Wednesday, 6/19/2013, we have revised our trend exhibit to display our annual trend. Additionally we added language to the CO Actuarial Memorandum to reflect this.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum_HHP (2014.01.01).pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*2 - Actuarial Memorandum CO HHP 2014_01_01.pdf*

Satisfied - Item:	Exhibit B - Trend Exhibits
Comments:	
Attachment(s):	Exhibit B - CO HHP Trend Exhibits.xlsx Exhibit B CO HHP Trend Exhibits.pdf
Previous Version	
Satisfied - Item:	*Exhibit B - Trend Exhibits*
Comments:	
Attachment(s):	*3 - Trend Exhibits.pdf*
Previous Version	
Satisfied - Item:	*Exhibit B - Trend Exhibits*
Comments:	
Attachment(s):	*4 - Exhibit B - Trend Exhibits.xlsx*

State: *Colorado* ***Filing Company:*** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Note To Reviewer

Created By:

Emma Erickson on 05/30/2013 01:57 PM

Last Edited By:

Emma Erickson

Submitted On:

05/30/2013 01:57 PM

Subject:

Revised Rate Sample Per Division's Request

Comments:

The rate sample has been uploaded in the format provided by the Division of Insurance via email recieved 5/29/2013. To comply with recent requests, I have uploaded both in excel and pdf format.

Please let me know if there is anything further I can assist with.

Thank you.

Emma Erickson

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Note To Filer

Created By:

Cathy Gilliland on 05/23/2013 09:24 AM

Last Edited By:

Cathy Gilliland

Submitted On:

05/23/2013 09:24 AM

Subject:

URRT

Comments:

Please provide the URRT is a xls format as we are not able to open the xlm

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Post Submission Update Request Processed On 06/05/2013

Status: Allowed
Created By: Emma Erickson
Processed By: Cathy Gilliland
Comments:

General Information:

Field Name	Requested Change	Prior Value
Product Name	HumanaOne Suite A HMOx; HumanaOne Suite C PPO	CO-71130-POS & CO-71129

Company Rate Information:

Company Name:Humana Health Plan Inc.

Field Name	Requested Change	Prior Value
# of Policy Holders Affected for this Program	0	5273
Written Premium for this Program	$0	$1615638
Product Names:	HumanaOne Suite A HMOx: HumanaOne Connect Basic 6350/6350, HumanOne Connect Bronze 6300/6300, HumanaOne Connect Silver 4600/6300, HumanaOne Connect Gold 2500/3500, HumanaOne Connect Platinum 1000/1500, HumanaOne Connect Bronze 4850/6350, HumanaOne Connect Silver 3650/3650. HumanaOne Suite C POS: HumanaOne Preferred Basic 6350/6350, HumanaOne Preferred Bronze 4850/6350, HumanaOne Preferred Silver 4250/6250, HumanaOne Preferred Bronze 6300/6300, HumanaOne Preferred Silver 3650/3650.	HumanaOne Suite A HMOx, HumanaOne Suite C POS
REQUESTED RATE CHANGE INFORMATION:		
Member Months:	0	91997
PRIOR RATE:		
Total Earned Premium::	0.000	12,796,012.000
Total Incurred Claims:	0.000	6,638,707.000
Min:	0.000	49.000
Max:	0.000	1,374.000
Weighted Avg.:	0.000	169.000

State: *Colorado* ***Filing Company:*** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Post Submission Update Request Processed On 06/25/2013

Status:	Allowed
Created By:	Emma Erickson
Processed By:	Cathy Gilliland
Comments:	

Company Rate Information:

Company Name:Humana Health Plan Inc.

Field Name	Requested Change	Prior Value
REQUESTED RATE CHANGE INFORMATION:		
Member Months:	91997	0

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: CO-71130-POS & CO-71129

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		CO Suite A HMOx	CO-71129	POLA	Initial			
2		CO Suite C POS	CO-71130-POS	POLA	Initial			

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Rate Justification

Rate Methodology
Experience Used for Rate Setting: Utilized the Humana Individual Block of business data for 2012. 2012 Experience Period Loss Ratio: 51.9 ased on 91,997 member months. This was a very new highly underwritten block of business still in 2012.
Annual Health Cost Trends: 9.6isk Adjustment: 0payments expected from the federal Risk Adjustment Program in 2014).
Reinsurance Recoveries: -11.5payments expected from the federal Reinsurance Program in 2014).
Final Disposition Letter
Smoking Factor: 10igher rates for smokers at all ages.
Age Rating: 3.0 to 1.0 age rating factor limits for all adults age 21 and over.
Colorado 2014 Overall Average Premium: $234.94
* Federal Reported 2014 Comparable Average Premium: $234.94
* This is reported on the issuerâ€™s CMS URRT Form submitted in HIOS. It represents a standardized average premium calculation that is used by CMS for comparing and gauging premium develpment. It is not necessarily the actual average premium, which is shown in the line above as Colorado 2014 Overall Average Premium.
Premium Retained to Cover Expenses, Taxes Fees and Profits Administrative costs: Expenses the insurance company pays to operate this insurance plan.
This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the companyâ€™s offices and equipment, commissions
to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes.
Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.
Premium retention is 25.1hown as follows:
f Premium
Issuer Primary Expense and Profit Retention
Retained
Administrative Expenses:
9.60
irect Response, Marketing,

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: File and Use
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Health Plan Inc.	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: *Colorado* ***Filing Company:*** *Humana Health Plan Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*
Product Name: *HumanaOne Suite A HMOx; HumanaOne Suite C PPO*
Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name:	Humana Health Plan Inc.
HHS Issuer Id:	74320
Product Names:	HumanaOne Suite A HMOx: HumanaOne Connect Basic 6350/6350, HumanOne Connect Bronze 6300/6300, HumanaOne Connect Silver 4600/6300, HumanaOne Connect Gold 2500/3500, HumanaOne Connect Platinum 1000/1500, HumanaOne Connect Bronze 4850/6350, HumanaOne Connect Silver 3650/3650. HumanaOne Suite C POS: HumanaOne Preferred Basic 6350/6350, HumanaOne Preferred Bronze 4850/6350, HumanaOne Preferred Silver 4250/6250, HumanaOne Preferred Bronze 6300/6300, HumanaOne Preferred Silver 3650/3650.
Trend Factors:	none

FORMS:

New Policy Forms:	CO-71129, CO-71130-POS
Affected Forms:	CO-71037
Other Affected Forms:	

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Annual
Member Months:	91,997
Benefit Change:	None
Percent Change Requested:	Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium:	0.00
Total Incurred Claims:	0.00
Annual $:	Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium:	132,385,931.00
Projected Incurred Claims:	99,249,732.00
Annual $:	Min: 84.00 Max: 1,332.00 Avg: 235.00

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2014 CO HHP Rate Manual	CO-71129, CO-71130-POS	New		CO HHP RATE MANUAL 01_01_2014.pdf,

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

CO-HHP
January 1, 2014
Rate Filing

Content	Page

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Average Premium

$234.95

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Plan Designs & Factors

Plan Marketing Name	HIOS Plan ID	Plan Suite	Plan Tier	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)	Off-Exchange (includes Ped. Dental)
Humana Connect Basic 6350/6350 Plan	74320CO0610001	Suite A	Catastrophic	$6,350	100%	$6,350	Integrated	0.7256	
Humana Connect Bronze 6300/6300 Plan	74320CO0610002	Suite A	Bronze	$6,300	100%	$6,300	Integrated	0.9132	
Humana Connect Silver 4600/6300 Plan	74320CO0610004	Suite A	Silver	$4,600	80%	$6,300	$1,500	1.0356	
Humana Connect Gold 2500/3500 Plan	74320CO0610006	Suite A	Gold	$2,500	80%	$3,500	$500	1.1812	
Humana Connect Platinum 1000/1500 Plan	74320CO0610007	Suite A	Platinum	$1,000	80%	$1,500	$500	1.3317	
Humana Connect Bronze 4850/6350 Plan	74320CO0610003	Suite A	Bronze	$4,850	80%	$6,350	$1,500	0.9843	
Humana Connect Silver 3650/3650 Plan	74320CO0610005	Suite A	Silver	$3,650	100%	$3,650	Integrated	1.0505	
Humana Connect Basic 6350/6350 Plan	74320CO0610008	Suite A	Catastrophic	$6,350	100%	$6,350	Integrated		0.7285
Humana Connect Bronze 6300/6300 Plan	74320CO0610009	Suite A	Bronze	$6,300	100%	$6,300	Integrated		0.9168
Humana Connect Silver 4600/6300 Plan	74320CO0610011	Suite A	Silver	$4,600	80%	$6,300	$1,500		1.0398
Humana Connect Gold 2500/3500 Plan	74320CO0610013	Suite A	Gold	$2,500	80%	$3,500	$500		1.1859
Humana Connect Platinum 1000/1500 Plan	74320CO0610014	Suite A	Platinum	$1,000	80%	$1,500	$500		1.3371
Humana Connect Bronze 4850/6350 Plan	74320CO0610010	Suite A	Bronze	$4,850	80%	$6,350	$1,500		0.9883
Humana Connect Silver 3650/3650 Plan	74320CO0610012	Suite A	Silver	$3,650	100%	$3,650	Integrated		1.0547
Humana Preferred Basic 6350/6350 Plan	74320CO0620001	Suite C - Rx4	Catastrophic	$6,350	100%	$6,350	Integrated		0.7603
Humana Preferred Bronze 4850/6350 Plan	74320CO0620003	Suite C - Rx4	Bronze	$4,850	80%	$6,350	$1,500		1.0269
Humana Preferred Silver 4250/6250 Plan	74320CO0620004	Suite C - Rx4	Silver	$4,250	80%	$6,250	$1,500		1.0739
Humana Preferred Bronze 6300/6300 Plan	74320CO0620002	Suite C - Rx4	Bronze	$6,300	100%	$6,300	Integrated		0.9128
Humana Preferred Silver 3650/3650 Plan	74320CO0620005	Suite C - Rx4	Silver	$3,650	100%	$3,650	Integrated		1.0554

Average Factor	1.0000

Cost Sharing Subsidized Plan Designs

Plan Name	HIOS Plan ID	Plan Suite	FPL	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)
Humana Connect Silver 4600/6300 Plan	74320CO0610004-03	Suite A	250+	$4,600	80%	$6,300	$1,500	1.0356
	74320CO0610004-04	Suite A	200 - 250	$3,250	80%	$4,750	$1,000	1.0356
	74320CO0610004-05	Suite A	150 - 200	$900	80%	$1,450	$500	1.0356
	74320CO0610004-06	Suite A	100 - 150	$500	80%	$750	$250	1.0356
Humana Connect Silver 3650/3650 Plan	74320CO0610005-03	Suite A	250+	$3,650	100%	$3,650	Integrated	1.0505
	74320CO0610005-04	Suite A	200 - 250	$2,920	100%	$2,920	Integrated	1.0505
	74320CO0610005-05	Suite A	150 - 200	$1,100	100%	$1,100	Integrated	1.0505
	74320CO0610005-06	Suite A	100 - 150	$475	100%	$475	Integrated	1.0505

In addition to the Silver plan variations shown above, all on-exchange metal tier plans will also have a 100% Cost Sharing Plan Design for American Indians/Alaska Natives, and for pricing purposes, will use the plan factors shown in the top table.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Age Factors

Age of Member	Factor	Demonstration of Compliance Factor compared to age 21
Fourth+ Dependents	0.0000	0.000
0-20	0.5372	0.635
21	0.8461	1.000
22	0.8461	1.000
23	0.8461	1.000
24	0.8461	1.000
25	0.8494	1.004
26	0.8664	1.024
27	0.8867	1.048
28	0.9197	1.087
29	0.9467	1.119
30	0.9603	1.135
31	0.9806	1.159
32	1.0009	1.183
33	1.0136	1.198
34	1.0271	1.214
35	1.0339	1.222
36	1.0406	1.230
37	1.0474	1.238
38	1.0542	1.246
39	1.0677	1.262
40	1.0813	1.278
41	1.1016	1.302
42	1.1210	1.325
43	1.1481	1.357
44	1.1819	1.397
45	1.2217	1.444
46	1.2691	1.500
47	1.3224	1.563
48	1.3833	1.635
49	1.4434	1.706
50	1.5111	1.786
51	1.5779	1.865
52	1.6515	1.952
53	1.7260	2.040
54	1.8063	2.135
55	1.8867	2.230
56	1.9738	2.333
57	2.0618	2.437
58	2.1558	2.548
59	2.2023	2.603
60	2.2962	2.714
61	2.3774	2.810
62	2.4307	2.873
63	2.4976	2.952
64+	2.5382	3.000

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Tobacco Use Factors

The following factors will be applied based on the member's tobacco usage, as determined by the tobacco usage guidelines.

Age of Member	Non-Tobacco User	Tobacco User	Demonstration of Compliance Factor compared to Non-Tobacco User
0-20	0.9941	0.9941	1.000
21	0.9941	1.0935	1.100
22	0.9941	1.0935	1.100
23	0.9941	1.0935	1.100
24	0.9941	1.0935	1.100
25	0.9941	1.0935	1.100
26	0.9941	1.0935	1.100
27	0.9941	1.0935	1.100
28	0.9941	1.0935	1.100
29	0.9941	1.0935	1.100
30	0.9941	1.0935	1.100
31	0.9941	1.0935	1.100
32	0.9941	1.0935	1.100
33	0.9941	1.0935	1.100
34	0.9941	1.0935	1.100
35	0.9941	1.0935	1.100
36	0.9941	1.0935	1.100
37	0.9941	1.0935	1.100
38	0.9941	1.0935	1.100
39	0.9941	1.0935	1.100
40	0.9941	1.0935	1.100
41	0.9941	1.0935	1.100
42	0.9941	1.0935	1.100
43	0.9941	1.0935	1.100
44	0.9941	1.0935	1.100
45	0.9941	1.0935	1.100
46	0.9941	1.0935	1.100
47	0.9941	1.0935	1.100
48	0.9941	1.0935	1.100
49	0.9941	1.0935	1.100
50	0.9941	1.0935	1.100
51	0.9941	1.0935	1.100
52	0.9941	1.0935	1.100
53	0.9941	1.0935	1.100
54	0.9941	1.0935	1.100
55	0.9941	1.0935	1.100
56	0.9941	1.0935	1.100
57	0.9941	1.0935	1.100
58	0.9941	1.0935	1.100
59	0.9941	1.0935	1.100
60	0.9941	1.0935	1.100
61	0.9941	1.0935	1.100
62	0.9941	1.0935	1.100
63	0.9941	1.0935	1.100
64+	0.9941	1.0935	1.100

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Geographic & Network Factors

The following factors will be applied according to the policyholder's place of residence.

		Geographic		Network		Geographic * Network	
Rating Area	Reference Market Name	HMOx	POS	HMOx	POS	HMOx	POS
1	Boulder	-	0.9773	-	1.5635	-	1.5280
2	Colorado Springs	0.8066	0.8066	1.1479	1.5635	0.9258	1.2611
3	Denver	0.9031	0.9031	1.0600	1.4757	0.9573	1.3328
4	-	-	-	-	-	-	-
5	-	-	-	-	-	-	-
6	-	-	-	-	-	-	-
7	-	-	-	-	-	-	-
8	-	-	-	-	-	-	-
9	-	-	-	-	-	-	-
10	-	-	-	-	-	-	-
11	-	-	-	-	-	-	-

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Plan Distribution

	New Business				Renewal Only	
	On-Exchange		Off-Exchange		Off-Exchange	
	Network		Network		Network	
Plan Suite	HMOx	POS	HMOx	POS	HMOx	POS
Suite A Suite C - Rx4 Refresh PHP	X		X	X		

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Definition of Service Areas

Service areas are defined by groups of counties.
For reference only. For complete plan availability, see the Service Area template.

		Network	
Rating Area	Reference Market Name	HMOx	POS
1	Boulder	n/a	Boulder
2	Colorado Springs	El Paso, Teller	El Paso, Teller
3	Denver	Adams, Arapahoe, Broomfield, Denver, Douglas, Jefferson	Adams, Arapahoe, Broomfield, Denver, Douglas, Elbert, Jefferson
4	-	n/a	n/a
5	-	n/a	n/a
6	-	n/a	n/a
7	-	n/a	n/a
8	-	n/a	n/a
9	-	n/a	n/a
10	-	n/a	n/a
11	-	n/a	n/a

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Modal Factors

The following factors will be applied according to the payment mode selected.
These factors will be applied at the end of the rate calculation.

Payment Frequency	Factor
Monthly	1.0000
Quarterly	3.0000
Semi-Annual	6.0000

An administrative fee of $5 will be charged for each paper bill generated and each recurring credit card transaction. The fee is waived for electronic funds transmission (EFT). A $25 fee is charged for checks returned with, or Electronic Fund Transactions resulting in, insufficient funds. A $25 fee is charged for late payment and a $25 fee is charged to reinstate a lapsed policy.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Algorithm Details

Step through this algorithm for each member.

	Average Premium
x	Plan Factor
x	Age Factor
x	Tobacco Use Factor
x	Geographic Factor
x	Network Factor
=	Subtotal *(rounded to nearest penny)*
x	Modal Factor
=	Rate

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Sample Rate Calculation

Plan: Humana Connect Bronze 6300/6300 Plan
Availability: On-Exchange (no Ped. Dental)
Tobacco Use: Non-Tobacco User
Rating Area: 3
Reference Market: Denver
Network: HMOx
Payment Mode: Monthly

			Mbr #1	Mbr #2	Mbr #3	Mbr #4	Mbr #5	Mbr #6	
		Age:	33	32	7	5	3	1	
	Average Premium		$234.95	$234.95	$234.95	$234.95	$234.95	$234.95	
x	Plan Factor		0.9132	0.9132	0.9132	0.9132	0.9132	0.9132	
x	Age Factor		1.0136	1.0009	0.5372	0.5372	0.5372	0.0000	
x	Tobacco Use Factor		0.9941	0.9941	0.9941	0.9941	0.9941	0.9941	
x	Geographic Factor		0.9031	0.9031	0.9031	0.9031	0.9031	0.9031	
x	Network Factor		1.0600	1.0600	1.0600	1.0600	1.0600	1.0600	
=	Subtotal *(rounded to nearest penny)*		$206.97	$204.37	$109.69	$109.69	$109.69	$0.00	
x	Modal Factor		1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
=	Rate		$206.97	$204.37	$109.69	$109.69	$109.69	$0.00	$740.41

Supporting Document Schedules

Bypassed - Item:	HR-1 Form (H)
Bypass Reason:	Per Colorado Divsion of Insurance guidance, the HR-1 Form is no longer required.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	** Please note that you must bypass this Requirement at initial submission since the required documentation will not yet be available.** This Requirement is applicable only to health insurance rate filings that meet or exceed the “subject to review” threshold established under Section 2794 of the Public Health Service Act (PHS Act), and the “Rate Increase Disclosure and Review” final rule (Rate Review Regulation) implementing section 2794 of the PHS Act.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	COHMOActuarialMemorandumandExhibitsrevised3.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	H1_SBE_CO_HMO_unified_rate_review fix.xls
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Attachment(s):	1- Cover Letter 2014-01.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	2 - Actuarial Memorandum_HHP (2014.01.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit A -CO HHP Past & Future Projected Experience
Comments:	
Attachment(s):	4 - Rate Filing Projection Exhibit 2014_01_01 CO HHP v2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit B - Trend Exhibits
Comments:	
Attachment(s):	Exhibit B - CO HHP Trend Exhibits.xlsx Exhibit B CO HHP Trend Exhibits.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Review Detail
Comments:	
Attachment(s):	5- 2014 Rate-Rule Schedule & Rate Review Detail.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Sample
Comments:	

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Attachment(s):	7 - CO HHP Rate Sample 2014_01_01.xlsx 7 - State of Colorado - Rate Sample.xlsx 7 - State of Colorado - Rate Sample.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Benefit Ratio Justification
Comments:	
Attachment(s):	8 - 2014 CO HHP Justification of Benefit Ratio.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Wellness Program & Rewards
Comments:	
Attachment(s):	WH02301 Accreditation Certificate.pdf WH02301 Final Letter.pdf HumanaVitality Longitudinal Study Slides.pdf Publication of HumanaVitality Longitudinal Study.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Plan & Benefits Template
Comments:	
Attachment(s):	H1_SBE_CO_PlansBenefits.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit C - CO HHP Base Rate Development
Comments:	
Attachment(s):	Exhibit C - CO HHP Base Rate Development.xlsx Exhibit C CO HHP Base Rate Development.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*HUMA-129026181*	***State Tracking #:***	*278044*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Humana Health Plan Inc.*
TOI/Sub-TOI:	*HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other*		
Product Name:	*HumanaOne Suite A HMOx; HumanaOne Suite C PPO*		
Project Name/Number:	*/*		

Satisfied - Item:	Geographic Area & Network Factor Build Up
Comments:	
Attachment(s):	CO GeoNet Build-Up 2014.01.01.pdf
Item Status:	
Status Date:	

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Attachment H1_SBE_CO_HMO_unified_rate_review fix.xls is not a PDF document and cannot be reproduced here.

Attachment Exhibit B - CO HHP Trend Exhibits.xlsx is not a PDF document and cannot be reproduced here.

Attachment 7 - CO HHP Rate Sample 2014_01_01.xlsx is not a PDF document and cannot be reproduced here.

Attachment 7 - State of Colorado - Rate Sample.xlsx is not a PDF document and cannot be reproduced here.

Attachment H1_SBE_CO_PlansBenefits.xlsx is not a PDF document and cannot be reproduced here.

Attachment Exhibit C - CO HHP Base Rate Development.xlsx is not a PDF document and cannot be reproduced here.

Humana Health Plan, Inc.
Colorado
HIOS Identification: 74320

This filing is for the individual market, with an effective date of 01/01/2014.

Contact Information:
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Purpose:

The purpose of this actuarial memorandum is to provide supporting justification to the Unified Rate Review template with the goal of demonstrating compliance with the market rating rules, as well as reasonableness of any proposed rates.

In addition, this actuarial memorandum provides required actuarial certifications related to:

- the methodology used to calculate the AV Metal Value for each plan
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based
- the index rate is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates

This filing should be used for no other purposes.

This memorandum was prepared by a qualified actuary, and is intended to be reviewed by a qualified actuary.

Reasons for Rate Increases

This actuarial memorandum accommodates our rates developed for new products.

The following paragraphs detail the components of the change in index rate used in development for our new 2014 products. Following a summary of the cumulative impacts at the beginning of this memo, we will walk through each item, how it impacts 2014 index rates, and the quantification.

Rate Increases Driven by Changes in Allowed Claims

A. Morbidity……	156.9%
B. Medical Inflation & Trend……	6.4%
C. Increased Utilization……	13.2%
D. Change in Benefits……	6.3%
E. Change in Demographics……	0.9%
F. Network Impacts……	-24.1%
Total……	151.9%

Other Rate Increase Drivers

G. New Taxes & Fees……	2.3%
H. Reinsurance Program……	-9.8%
I. Risk Adjustment……	0.0%
Total……	-7.7%
Grand Total……	132.4%

A. Single risk pool experience which is more adverse than that assumed in the current rates & morbidity:

This adjustment is intended to capture the change in underlying morbidity for the risk pool in 2014 compared to the current risk pool. Due to the removal of pre-existing condition limitations combined with 2014 rules disallowing underwriting rate adjustment or exclusionary riders, it is anticipated that the average morbidity for policies issued in 2014 will be much greater than the average morbidity in the individual market today.

Morbidity levels are expected to be similar to those of small group given that the underwriting will be similar between the segments in 2014. It is reasonable to assume that individual morbidity will be higher since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas, in the small group market, it is a by-product of being employed by the organization. Similarly, the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market. For these reasons, the starting point for developing the 2014 guaranteed issue impact is gauging the relative morbidity between the individual and small group markets today. External consultants were also worked with to estimate the impact of the new single risk pool experience.

Increased utilization due to the impact of member behavioral changes when on a plan with richer benefits must be accounted for. This excludes the impact of health status. Further detail on the impact of increased utilization by plan and level of cost sharing subsidization is detailed later in the actuarial memorandum.
The impact of morbidity in Colorado for Humana Health Plan, Inc. is 156.9%.

B. Medical inflation & medical cost claims trend:

Rate increases required to account for increases in medical claim costs were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.
The impact of medical inflation and medical cost claims trend from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 6.4%, or 3.1% annualized.

C. Increased Utilization

Rate increases required to account for increases in utilization were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.
The impact of increased utilization from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 13.2%, or 6.4% annualized.

D. Change in Benefits

All non-grandfathered plans must cover the essential health benefits package in 2014. The specifics of the essential health benefits are contained within the benchmark plan selected in each state.
There are two high level categories of benefits that require rate increases to account for in the individual market: behavioral services and other state-specific services.
Current plans do cover behavioral services but also impose visit limits as well as lower coinsurance rates and separate deductibles. The modification of cost sharing requires additional rate to cover the expected increase cost of services. State specific requirements embedded in the benchmark plan must also be provided and rates adjusted in accordance.
Please note, maternity coverage is already mandated in Colorado. An adjustment was made to account for the level of maternity claims expected in 2014 compared to the low level of maternity claims in the base experience period.
The impact of change in benefits in Colorado for Humana Health Plan, Inc. is 6.3%.

E. Change in Demographics

The change in demographics is meant to represent the shift in area mix of business distribution between 2012 and the new 2014 environment.
With the anticipated growth for 2014 and strategic selection of where products will be sold both on and off-exchange, there is an expected impact to the distribution of business by area. Since claim costs are known to vary by area, it is important to reflect this change.
The impact of change in demographics in Colorado for Humana Health Plan, Inc. is 0.9%.

F. Network Impacts

New products in 2014 will be tied to new networks in many markets, particularly on exchange where network selection was made in order to achieve lower claim costs. There are four components to the network savings: improved network discounts, removal of out-of-network coverage, new pharmacy network and formulary, and care coordinator savings.
The impact of these network impacts in Colorado for Humana Health Plan, Inc. is -24.1%.

G. New Taxes & Fees Imposed on the Insurer

There are two additional taxes and fees for 2014 that must be considered in the pricing:

1) 1.4% additional federal tax

2) Exchange user fee of 0.9% of premium

The additional federal tax is the $8 billion tax assessed on the insurance industry for 2014. Humana's estimated liability based on net premium share of the market is $505M. Price adjustments are required to reflect the liability compared to the estimated 2014 company premium revenue. This is not tax-deductible, the appropriate increased federal income tax liability is captured in the income tax line in the expense exhibit discussed later in the actuarial memorandum.

The exchange user fee applies only to on-exchange business but must be spread across all business.

The impact of new taxes and fees imposed on the insurer in Colorado for Humana Health Plan, Inc. is 2.3%.

H. Changes in payments from and contributions to the Federal Transitional Reinsurance Program

Rate adjustment to account for projected reinsurance recoveries net of reinsurance premium were also included in the rate development. Details of how projections were established and the corresponding magnitude are discussed at greater length later in the memorandum.

The impact driven by the Federal Transitional Reinsurance Program in Colorado for Humana Health Plan, Inc. is -9.8%.

I. Risk Adjustment

The impact of risk adjustment in Colorado for Humana Health Plan, Inc. is 0.0%

Additional Commentary on Reasons for Rate Increases

It should be noted that given the timeline of release of regulations, template requirements, and submission deadlines, pricing methodologies different from those prescribed by the Universal Rate Review Template were employed to develop 2014 pricing.

Experience Period Premium and Claims

Paid Through Date:	February 28, 2013	
Premiums net of MLR rebate:	$	12,811,963
MLR Rebates:	$	15,951
Estimated Rebates to be included:	$	-

Methodology for estimated Rebates: Rebates are the year-end accrual for 2012. The estimate was based on actual claims through the end of September 2012, with data projected through the end of the year. Since we have no state and legal entities that are fully credible in 2012 on their own, the 2012 rebates are based on two years worth of data. The 2011 data utilizes the submission used to generate rebates for the 2011 experience. Expense adjustments allowed under the rebate rules are estimated based on expense experience and future expectations.

	Allowed Claims	Incurred Claims
Claims that were processed through the issuer's claim system	$ 10,787,110	$ 6,235,799
Claims that were processed outside the issuer's claim system	$ 964,462	$ 194,443
Claims incurred but not paid as of paid through date	$ 380,980	$ 208,465

The processed claims are claims incurred in 2012 paid through February 2013. The allowed amount comes directly from the claims system after eligibility and network discounts are applied.

To estimate incurred claims, reserve cells are categorized at the product and type of service detail and development methods with various averaging techniques are utilized, most commonly a six-month average excluding the high and low factors. Smoothing techniques are employed, including workday and seasonality adjustments. Changes in claim volume are included in these estimates by adjusting for pended claims.

For each month of incurral, the incurred but not reported amount equals the incurred claims estimate minus claims paid to date.

Follow-up studies, including monthly historical reserve restatement analyses, are regularly performed to test the accuracy of the reserving methodology and suggest possible improvements.

Allowed but not reported estimates are developed utilizing the combination of the incurred but not reported estimate and the incurred to allowed ratio of historical claims.

Benefit Categories

The Benefit Categories are defined as follows:

Inpatient Hospital: Includes non-capitated services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility. The Outpatient Hospital benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Outpatient Surgery and Emergency Room, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Outpatient Therapy or MRI, services are used for the measurement units.

Professional: Includes non-capitated primary care, specialist, therapy, laboratory, radiology, and other professional services not billed by the facility. The Professional benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Primary Care or Specialist Office visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Therapy or MRI, services are used for the measurement units.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. The Other Medical benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Home Health visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as DME, services are used for the measurement units.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. Costs are net of rebates received from drug manufacturers, as required.

Projection Factors

156.9% **Changes in the Morbidity of the Population Insured [A]**

This adjustment is intended to capture the change in underlying marketwide (i.e., entire state of Colorado) morbidity for the risk pool in 2014 compared to the current risk pool. To calculate the change in morbidity, both internal pricing analysis and consultant reviews were utilized. Internal modeling considered the relative morbidity of the current uninsured market, combined with the relative morbidity of the membership on employer plans and the migration between segments. It is additionally anticipated that the resulting morbidity for the new 2014 business that will be issued in the individual market will be slightly higher than the morbidity levels of the small group market in 2014. Intuitively, morbidity levels similar to those of small group are expected given that the underwriting will be similar between the segments in 2014. The fact that individual morbidity will be higher is also a reasonable assumption since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas in the small group market, it is a by-product of being employed by the organization. Similarly the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market.

This data was adjusted to account for relative morbidity differences between the two segments, geographic mix differences, anticipated difference between the coverage of benefits, level of large claims, and new presence of richer benefits inducing additional demand. Analysis included consideration for the amount of new membership for the issuer at a higher morbidity level compared to the amount of existing membership at a lower morbidity level and change in renewal patterns. Internal modeling utilized consultant feedback for both growth factor estimates and also as a reasonability check.

The impact of morbidity, part of [A] above, is 58.7%.

The policy reserve adjustment is a portion of the MLR calculation that is unique to individual medical for policies effective in 2013 and earlier.

It is an MLR leveling mechanism that is needed to account for the fact that early duration loss ratios are significantly lower than later duration loss ratios.

The factors used for this adjustment were developed by comparing the claims over premium to claims plus change in policy reserves over premium in the experience period.

The change in reserves is the amount intended to levelize the claims plus change in policy reserves over premium ratio over the course of the policy life and therefore is used as a measure for how much the claims need to be modified by to get to an average lifetime level of morbidity. The source of the policy reserve data is the change in policy reserve information for the single risk pool.

The impact of the policy reserve adjustment, part of [A] above, is 53.1%.

The plan mix adjustment represents the impact to the allowed claims due to the anticipated change in benefit selection patterns between the base 2012 experience period and projected 2014 rating period.

This state's 2012 experience base is comprised of a relatively leaner benefit plan mix than we expect to have in 2014, due to the more select, healthier composition of the population underlying it.

In order to account for the absence of such positive selection in a more standard 2014 population, the allowed claims have increased.

This impact was quantified by comparing the anticipated 2014 benefit plan distribution against that which underlies the state's specific 2012 experience base.

Each was weighted by 2012 premiums for each benefit plan, normalized for the difference in paid to allowed ratio.

The impact of the plan mix adjustment, part of [A] above, is 5.8%.

6.3% **Changes in Benefits [D]**

As outlined in the "Reasons for Rate Increases" portion of the memorandum, this reflects the changes in benefits available to membership including adding maternity benefits, modification for behavioral health services cost-sharing and state mandated benefits as function of the benchmark plan. The data used to derive the estimated impact of adding maternity coverage was based on Humana Small Group data since many Humana individual plans currently do not include maternity coverage in the state. The methodology employed was comparing the level of maternity claims compared to the total claims. This was adjusted to account for anticipated increase in maternity incident rates given the mix of business differences between small group and individual by federal poverty levels. The estimated impact of the contraceptive coverage under the Women's Preventive Care legislation was additionally taken into account as an offset to the higher incidence rates.

The data used to derive the estimated impact of changes in member cost-sharing levels for behavioral health services was based on small group data as well. This exercise started with an analysis of behavioral health claims compared to total and compared the marginal benefit ratio of the new and current plans that will result due to the Federal Mental Health Parity requirements. State specific mandated benefits based on the benchmark plans were determined individually using similar methodologies.

0.9% **Changes in Demographics [E]**

This factor represents the impact to the allowed claims with respect to the change in demographics between the base 2012 experience period and the expected demographic mix in 2014.

The process used to derive the change in area began with the distribution of business in 2012 and expected in 2014 by state and legal entity. Each of these was weighted with average premium per member per month in each state and legal entity market. The change in the overall state and legal entity's weighted premium per member per month dictated the expected impact due to the shift to the new 2014 geographic distribution. Age and gender were held constant in this exercise.

-24.1% **Other Adjustments - Network Impact [F]**

This factor represents the impact to the allowed claims with the presence of new networks on new products in 2014 in many markets. Data used to evaluate this claim impact is based on Humana claims at a corporate level as well as the individual market. To generate the estimated impact, network savings were generated relative to the base network underlying the current products.

Additionally for new HMO networks, the reduction in claims achieved by removing out-of-network coverage was determined by comparing the average cost per service in-network compared to the cost per service out-of-network. Also for new HMO networks an adjustment was made to account for the presence of a new pharmacy network. Finally network claim impacts account for the estimated savings for care coordinators as part of a HMO network to manage referrals for specialty care and inpatient stays.

20.4% **Trend Factors: Cost & Utilization [B & C]**

The cost trend captures pure unit cost changes from midpoint 2012 to midpoint 2014, calculated using the same basket of services each period, due to price/contract negotiations and provider distribution changes. Inpatient Hospital, Outpatient Hospital, Professional, Capitation and Other Medical cost trends are developed based on historical area specific cost trends from Humana's Individual Commercial block of business data. Future cost trends are developed based on expected changes in Humana's Commercial contracts.
Pharmacy cost trends are developed based on historical brand, generic, and specialty drug trends from Humana's Commercial data. Future cost trends are developed based on expected changes in these pharmacy contracts.

These contractual impacts will be applicable to all members regardless of risk class.

Utilization trend:
Using Humana's Trend Quantification and Projection model, a baseline utilization trend is developed using Humana's Individual Commercial block of business historical medical claims data from 2008 - 2012. The historical baseline utilization trend is developed by removing all known impacts to utilization net trend such as demographics, geography, duration, customer changes, benefit changes, new health technologies, utilization management initiatives, and changes in pertinent days. An economic regression model, based on consumer sentiment, personal disposable income, hospital construction, and high-tech medical equipment spend, is then fit to this historical baseline utilization data to project the future block of business baseline utilization trend for 2013 and 2014.
A midpoint to midpoint methodology is applied to determine the applicable baseline utilization trend, which incorporates 2012q3 and 2012q4 actual results at the state and legal entity level with the block of business baseline utilization trend for 2013 and 2014. This results in baseline utilization trends that vary at the state and legal entity level.

Other components are added to the baseline utilization trend to develop the total utilization trend provided. These include the following:
• Pertinent days – Captures changes in the calendar, recognizing that health care utilization varies by day of the week and reporting periods contain varying weekday mix and count. This impact is developed through the use of an external consultant's model which is uploaded with Humana's Commercial claims data.
• New Health Technologies – Captures the impact of new health technologies and procedures. An external consulting firm researches new technologies and develops per member per month impacts. These impacts are customized to Humana's Commercial business based on membership and coverage policy.
• Management Initiatives – Captures savings for Humana initiatives designed to bend trend by managing utilization, such as case management, disease management, and nurse programs. These initiatives are evaluated by an internal actuarial organization tasked with evaluating the effectiveness of the initiatives. Evaluations are done through a collaborative effort involving clinical and other operational areas. Projected savings are calculated by determining prospective changes to impacted metric values, which are determined by analyzing historical metric values as well as through discussions with clinical and operational areas. Savings are reviewed with leadership to ensure appropriateness of assumptions.
This describes the development of the core utilization trend. All impacts from healthcare reform have been removed and are included in the "Population Risk/Morbidity" and "Other" adjustments from Worksheet 1 to prevent double counting of any impacts.

Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used, Adjustments Made to the Data, Inclusion of Capitation Payments

To credibility adjust this block of business, a credibility manual consisting of slight modifications to 2014 market projections was utilized.

Source data utilized for the credbility manual calculation includes Colorado Humana Health Plan, Inc. utilization per 1000 that mirrors the 2014 projected experience, adjusting to reflect the overall credibility of the block of business that we apply in pricing to ensure adequacy of rates.

The average cost per service is driven by the Colorado Humana Health Plan, Inc. 2014 projected experience in order to maintain representation of the provider contracts and distribution mix represented in the allowed claim derivation, also adjusted to reflect the credibility of the block of business to ensure pricing adequacy.

We do not expect to have services in the projection period provided under a capitation arrangement.

Credibility of Experience

The state of Colorado has mandated a level of 24,000 member months for full credibility. Per that mandate, our credibility weight methodology has been adjusted to reflect utilizing the following equation: square root(member months in experience period/24000).

To account for the presence of Colorado Humana Health Plan, Inc. experience in the credibility manual, the credibility level afore mentioned has been reduced by a factor of the expected 2014 membership relative to nationwide.

Paid to Allowed Ratio

The anticipated paid to allowed average factor over the projection period was developed by separately considering the anticipated paid to allowed factors by individual plan tier.

Once calculated, projected member month weights for each plan tier (consistent with those provided in Worksheet 2) were applied to these paid to allowed factors to produce an overall anticipated paid to allowed average factor of 60.2%.

The individual plan tier paid to allowed factors were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. These values were developed in accordance with generally accepted actuarial principles and methodologies.

Risk Adjustment and Reinsurance

Projected Risk Adjustment PMPM

We are reflecting an overall neutral impact of the risk adjustment program ($0.00 PMPM) on this legal entity in 2014 in the build-up of our single risk pool gross premium average rate, PMPM.

Projected Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance recoveries were calculated using claims data from the simulated populations mentioned above. Humana Small Group membership was used to represent the risk of new enrollees in 2014. This is expected to be a reasonable approximation of this cohort's risk characteristics. Humana Individual membership was used to model the risk of members renewing in 2014. The recoveries in column E of Exhibit 1 are a blend of these two populations. Paid claims were calculated for each member based on their allowed claims and the plan selected in the simulation. As specified by HHS, recoveries were calculated for members with total calendar year claims exceeding the $60,000 attachment point. The recoveries apply an 80% coinsurance rate up to a cap of $250,000.

To ensure statistical credibility, the estimate was calculated using nationwide membership and experience. However, the Colorado specific estimate was calculated by adjusting the nationwide allowed claims for the unit cost differences in Colorado.

A portion of reinsurance recoveries are offset by the reinsurance assessment of $5.25 PMPM. We expect recoveries net of assessments to be $23.05 PMPM which results in a -9.8% adjustment to premium. In compliance with rating rules, all plan premiums are adjusted uniformly by -9.8% as demonstrated in column I of Exhibit 1.

Note that the Unified Rate Review template contains reinsurance recoveries net of assessments wherever reinsurance estimates are requested. This approach was selected because it allows the values in Worksheet 2a to tie back to values from Worksheet 1. The value of reinsurance recoveries can be obtained by adding $5.25 PMPM to each estimate.

Induced Utilization

In this context, Induced Utilization refers to the utilization impact of member behavioral changes when on a plan with richer benefits. This metric does not include the impact of health status.

The induced utilization assumption of 0.9% was developed by applying adjustments to the plan specific factors provided by HHS in the Notice of Benefit and Payment Parameters.

We anticipate the effect of induced utilization to be somewhat less than the original factors suggest, so we have adjusted the factors lower. It is important to note that the assumed impact only accounts for the incremental induced utilization in excess of the induced utilization observed on an average pre-reform plan. This approach is used to avoid double-counting the impact of induced utilization.

Catastrophic versus Non-Catastrophic Allowed Claims

Federal rating rules allow issuers to adjust the index rate for the level of gross claim costs anticipated for Catastrophic plan enrollees. Column B of Exhibit 2 shows allowed claims for the simulated members on Catastrophic and Metal plans. The simulation strictly adheres to the Catastrophic plan eligibility rules and uses member utility to determine plan selections. In the simulation, members eligible for subsidies tend to select Silver plans rather than Catastrophic plans. In addition, less healthy members tend to select plans with richer benefits than the Catastrophic plan. This results in a significantly lower allowed cost for members selecting the Catastrophic plan.

The ratio of Catastrophic allowed claims to total allowed claims across all plans (column C) is used to adjust the overall index rate for Catastrophic plans. This is a -21.3% adjustment to the index rate.

Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust index rate used for Metal Plans and results in a 1.7% adjustment. This small adjustment for Metal plans is necessary to ensure the overall index rate for the single risk pool remains unchanged.

Non-Benefit Expenses and Profit Risk

Expenses are based on our internal forecast for 2014. Expenses are estimated based off of current costs, projected volume changes and estimated changes in department workload. These expenses are simply loaded as a flat percentage of premium at this point in time and do not vary by product or plan.

16.8% Administrative Expense Load

- Broker & Sales Commissions: Compensation expenses associated with business issued through an agent or agency
- Quality Expenses: Expenses associated with quality that are allowed adjustments under the Medical Loss Ratio standards
- Clinical & Network Operations: non-quality clinical costs, provider contracting, and network maintenance & development
- IT Expenses: costs associated with maintenance and development of systems
- Customer Service & Account Installation: call center, customer service, and account management
- Corporate Administration: shared functions that are not exclusive to individual major medical, including corporate finance, legal, human resources, etc.
- Individual Administration: functional areas & personnel that solely work on individual major medical
- Direct Response, Marketing, & Agency Management: direct to consumer marketing expenses, other marketing expenses and agency management expenses

3.1% Profit (or Contribution to Surplus) & Risk Margin

- Profit margin is shown on a post-income tax basis and does not include investment income. The margin shown does not vary by product or plan.

5.1% Taxes and Fees

0.3% • State Premium Tax: state premium tax; charged on a percentage of premium

1.4% • Health Insurer Annual Fee: assessment created in 2014 by PPACA. Estimated at 1.4% of premium. Not income tax deductible.

0.9% • Exchange Fee: charged on a percentage of premium basis to fund the exchange

0.1% • Other Misc Taxes: includes state licensing fees & the Federal Comparative Effectiveness Tax

2.5% • Income Tax: Federal income tax. Estimated as 36% times the sum of pretax profit margin and the non-deductible Health Insurer Annual Fee

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is at least 80%.

Demonstration:

(2014 Claims/2014 Premium) + (Quality Expenses as a % of Premium))/(1 - Taxes and Fees as a % of Premium)

((99,249,732 / 132,385,931) + 1.2%)/(1 - 5.1%) = 80.3%

Index Rate

The index rate for the experience period is simply the allowed claims per member per month in 2012 for all non-grandfathered plans. An adjustment is made to remove the impact of non-EHB state mandated benefits from the experience period allowed claims (see below for details); it is implicitly assumed that all other allowed claims for 2012 were for essential health benefits.
The index rate for the projection period is the credibility manual weighted allowed claims per member month multiplied by the proportion of allowed claims associated with essential health benefits, thereby excluding state mandated covered benefits and other covered benefits in excess of essential health benefits.

State mandated covered benefits that are included in allowed claims but excluded from the index rate include home health care services and physical, occupational, and speech therapy for congenital defects.

Covered benefits in excess of essential health benefits and state mandates that are included in allowed claims but excluded from the index rate include chiropractic care, organ transplants, and routine footcare.

The following market-wide adjustments are applied to the projected index rate as the first step in determining plan level “index” rates:

1) Adjustments for the net impacts of both risk adjustment and reinsurance. See "Risk Adjustment and Reinsurance" earlier section for more details of this market-wide adjustment.

2) An adjustment for the anticipated cost of exchange user fees.

The user fee cost of 1.4% of premiums has been applied to the estimated percentage of 2014 premiums from membership enrolled on the exchange.

It is included in the development of the overall index rate adjustment for this legal entity in this state.

3) Expense estimates (excluding exchange user fees) were based on our internal forecast for 2014. They were estimated based on current costs, modified to accommodate projected volume changes and changes in department workload. These are presented as a flat percentage of premium at this point in time and do not vary by product or plan, and thus are essentially another market-wide adjustment applied to the projected index rate.

4) An adjustment for the addition of non-EHB benefits (additional benefits we provide at our own discretion, as well as any state mandated benefits not reflected in the benchmark plan – typically individual market only mandates). It is assumed that the addition of such benefits increases costs to all plans uniformly, hence it is essentially handled as a market-wide adjustment.

Then the following plan-specific adjustments are applied to determine plan level “index” rates:

5) The individual plan tier pricing actuarial values (AVs) were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. The data used to produce the HumanaOne pricing AVs was based on a standard population of commercially insured membership purchased from a third party vendor. In order to provide the level of detail necessary for the analysis, internal data was used to subdivide the claims experience but the overall utilization level was calibrated to a standard population derived from a multitude of commercial insurers across a broad geographic area. Using this data, a seriatim (member-by-member) model was developed with the standard population data and projected 2014 annual claims by benefit category. Then, the 2014 plan design parameters were applied to those allowed claims to produce paid claims and pricing AV’s. These values were developed in accordance with generally accepted actuarial principles and methodologies.

The resulting plan-specific AV relativity to the overall AV across all plans is applied to the index rate to account for the plan-specific differences in AV and cost sharing.

6) The development of the index rate includes the anticipated average unit costs derived from the provider networks that will be available on this legal entity in this state. These average unit costs are the result of charge levels, network discounts, delivery system characteristics and utilization management practices across the entire state, for this legal entity.

As permitted, an adjustment is made to each plan rate to account for the specific cost differences from each provider network, in each allowed rating area, compared to the overall average across all plans.

Finally, with respect to Catastrophic plans, the following adjustments are made:

7) The ratio of Catastrophic allowed claims to total allowed claims across all plans is used to adjust the overall index rate for Catastrophic plans (reference the previous section on Catastrophic plans for more detail).
8) Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust the index rate used for Metal Plans to ensure the overall index rate for the single risk pool remains unchanged (again, please reference the previous section on Catastrophic plans for more detail).

AV Metal Values

The AV Metal Values indicated in Worksheet 2 of the Part 1 Unified Rate Review Template were determined using the AV Calculator for all new plans.

AV Pricing Values

The fixed reference plan used as the basis for the AV Pricing Values in Worksheet 2 is: Humana Connect Silver 4600/6300 Plan.

Membership Projections

In determining anticipated membership, two internally developed models are used. The first projects overall membership volume based on anticipated market growth, in-force persistency, and relative competitiveness. The second functions independently and produces specific plan tier mixes based on consumer selection behaviors. These two elements are combined to produce the projected membership volumes by plan tier found in Worksheet 2 of the Unified Rate Review Template. Each is described in further detail in Parts I & II, below.

Part I

In projecting overall membership volume across the state, we start with today's estimated total statewide market size and market shares by carrier (based on 2011 SHCE). Along with Humana, the model considers three other "carriers" in the state, two of which are based on the major carriers in the market today and a third which represents the balance of the market. Assumed competitive price relativities are then used to derive a percentage share of 2014 sales by carrier. We believe using these price relativities as the primary determinant of sales share in our modeling to be appropriate, due to increased sensitivity to price in the 2014 marketplace.

Due to the changes occurring in 2014 (guaranteed issue requirements, individual mandate, etc.), the model also makes assumptions for the growth and disruption that will transpire.

We assume the individual market in this state will grow by a factor of 1.70 relative to current market size and that 15.0% of in-force membership will lapse to seek coverage under the new market rules.

These assumptions were set globally across all modeled carriers in the state, given the limited carrier-specific information available at this time.

Together, these market size growth and lapse assumptions create an initial 2014 membership base on which the previously developed sales shares by carrier are applied to create membership sales volume estimates. All sales are assumed to occur on January 1, 2014, thus creating 12 months of exposure for each sold member.

The resulting total exposure created by these sales for Humana is projected to be 563,479 member months (a) on the Humana Health Plan, Inc. legal entity.

Part II

For the purposes of further projecting this membership by individual plan tier, a simulation was developed to model consumer behavior with regard to risk aversion, utility, and affordability. In particular, it considers eligibility for the various premium and cost sharing reduction subsidies by applying a single assumed nationwide income distribution (as a percent of FPL). Internal nationwide small business claims and membership data was used in developing the simulated population, since we believe this experience base provides the best available approximation of the anticipated 2014 risk pool. In general, the simulation assumes that members eligible for cost sharing reductions, based on their income relative to the federal poverty level, are expected to significantly tend toward choosing the applicable silver variant plan, due to its relative value proposition. This tendency becomes less pronounced as the percent of FPL increases.

Member month projections by plan tier (including the CSR silver plan variants) are produced by combining the results of Parts I & II with the developed information detailed above. The results are summarized below:

Plan Tier	Projected Member Months	Percent of Total
Catastrophic	42035	7%
Bronze	241481	43%
Silver	229907	41%
Gold	33459	6%
Platinum	16597	3%
Total	**563479**	**100%**

CSR Variant	Projected Member Months	Percent of Total
70%	122003	22%
73%	24416	4%
87%	49796	9%
94%	33692	6%
Silver Total	**229907**	**41%**

We expect the distribution of our business to shift within the state in direct response to the changes in provider and network deals, and therefore anticipated competitive position, by market. Sales in 2014 will concentrate in areas where there have been the most pronounced improvements; in the absence of such improvements, the geographic distribution across the state is expected to remain relatively constant from the current to the projection period. This is accounted for in the modeling methodology described above.

Terminated Products

HIOS Entity Name	State	Issuer ID	Product Smart ID	Product Name
Humana Health Plan	CO	74320	74320CO035	HumanaOne PHP Refresh
Humana Health Plan	CO	74320	74320CO049	HumanaOne HMO
Humana Health Plan	CO	74320	74320CO060	HumanaOne HMO

Effective Rate Review Information

URR Approach

This section describes how the URR template values were populated in instances where the instructions were unclear or the template's functionality was unable to accommodate the appropriate values.

- Rate change % over prior filing (row 25) was populated with the change between rates effective 1/1/2014 and rates effective 12/31/2013. The previous rate filing contained rates that were effective through the end of 2013. Therefore, the 2014 rate is compared to the last rate in effect on 12/31/2013.
- Cumulative Rate Change % over 12 months prior (row 26) was populated with the change between rates effective 1/1/2014 and rates effective 1/2/2013. This captures the change in the rates over precisely one year.
- Projection Period Rate Change % over Experience Period (row 27) is a calculated formulaically by the template. However, it is important to note that this measure can be subject to significant variability. In our 2014 projection we assume a constant distribution of membership by age and geography. The rates for each plan were developed using the same distribution and is reflected in the average premiums (row 80). However, in row 27 this is compared to earned premiums from the experience period. The experience period will have a significantly different distribution of membership by age and geography than in the projection. As a result, row 27 will reflect changes in mix as well as changes in rates. This results in significant volatility for plans with limited membership during the experience period.
- Section IV of Worksheet 2 contains several inconsistencies between the calculated rows and the warning checks. These inconsistencies are primarily due to the definition of Total Allowed Claims (row 86). The warning check and the template instructions both indicate that the impact of reinsurance and risk adjustment should be included in Total Allowed Claims. However, formulas that refer to row 86 use it as if the impact of reinsurance and risk adjustment were not included. This results in double counting and inappropriate application of these items in rows 93, 98 and 99. Our approach was to follow the template instructions when populating row 86 and then explain the warnings that get generated in the subsequent rows. Explanations for the warnings can be found later in the memorandum.
- The net impact of risk adjustment (row 96) does not accept negative values if entered manually. However, we have found that populating this row via copy/paste will validate successfully. Therefore we have populated the template using this technique when necessary.

Warning Alerts

Worksheet 1, Rows 24-29, Column K:

Warnings have been generated in rows 24-29, column K for the 'other' adjustment. We expect a net reduction in rates for the adjustments embedded in this column and therefore a value less than 1.0 is being applied. Details of the components of the 'other' adjustment have been described in a previous section.

Worksheet 2, Row 82:

A warning has been generated in row 82. The values in this row are based on the sum each plan's projected premium based on the plan's projected membership and average rate pmpm. The warning in row 80 allows for a 2% tolerance level when comparing to the value depicted on Worksheet 1, but the Worksheet 2 tolerance level requires equivalence. This slight variation makes a perfectly equivalent premium match highly unlikely. The worksheet 2 results are within a tolerable range of the worksheet 1 value.

Worksheet 2, Rows 83-85:

A false error is populating for rows 83-85 in all columns suggesting the three values do not add to 100%. This is incorrect; based on the formula in row 85, it is impossible for this to be true. Values have been appropriately populated.

Worksheet 2, Rows 93, 98, 99:

Warnings have been generated in rows 93, 98, and 99 for the same reason. The values in these rows are all based on the values in Total Allowed Claims (row 86) and per the template instructions this includes the impact of reinsurance and risk adjustment. This is inconsistent with how this value is used by template formulas and comparisons to values on Worksheet 1. Rows 93 and 98 are calculated based on row 90 which includes the impact of reinsurance and risk adjustment. Row 90 is subtracted from row 86 causing the impact of reinsurance and risk adjustment to be double counted. Warnings are generated when these numbers are compared to values from Worksheet 1 that include these impacts properly. In addition, Row 99 is calculated based on row 86 (which includes reinsurance and risk adjustment), but validated using a value from Worksheet 1 that does not include reinsurance and risk adjustment.

Reliance

I, Stephen Arnhold, relied on information and underlying assumptions provided by internally developed pricing and modeling as well as third party consultant data in the establishment of these rates.

Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify, to the best of my knowledge, that the projected index rate is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), developed in compliance with the applicable Actuarial Standards of Practice, reasonable in relation to the benefits provided and the population anticipated to be covered, and neither excessive nor deficient.
I certify, to the best of my knowledge, that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
I certify, to the best of my knowledge, that that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.
I certify, to the best of my knowledge, that that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

This opinion is qualified, in that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Actuary signature: 

Actuary Printed Name: Stephen Arnhold, FSA, MAAA

Date: July 15, 2013

Colorado
Humana Health Plan, Inc.
Exhibit 2
Catastrophic/Non-Catastrophic Index Rate Adjustment

	A	B	C	
	% of Members	Allowed Claims PMPM	Index Rate Adjustment	
Humana - HHP	12%	330.85	1.000	
Catastrophic	8%	260.37	0.787	= 260.37 / 330.85
Metal Plans	92%	336.40	1.017	= 336.40 / 330.85
Bronze	42%	336.40	1.017	= 336.40 / 330.85
Silver	41%	336.40	1.017	= 336.40 / 330.85
Gold	6%	336.40	1.017	= 336.40 / 330.85
Platinum	3%	336.40	1.017	= 336.40 / 330.85

*__Special Note__: The above exhibit reflects the final pricing used in developing the rates proposed in this submission. Late-breaking guidance was given to discontinue existing products in this legal entity, and due to time constraints we were not able to incorporate said guidance into the final pricing; however, we do not believe this to result in a material change to the final rates as submitted.

We were able to revise our projected sales and membership to reflect this guidance, which is why there is a slight inconsistency in the membership weights shown above and in the "Membership Projection" section of the accompanying memorandum.

P.O. Box 1633
Waukesha, WI 53187-1633

State of Colorado

Cover Letter
HUMANA HEALTH PLAN, INC. #119-95885
Policy Form Series CO-71130-POS & CO-71129
May 14, 2013

Dear Sir or Madam,

We respectfully submit for your review the enclosed premium rates for use with the above captioned policy series. See the actuarial memorandum for more information about this filing.

If you have any questions regarding this filing, please contact me by phone at 920.337.8573 or by email at eerickson@humana.com.

Sincerely,

Emma Erickson
Actuarial Analyst
Individual Product Segment

STATE OF COLORADO
HUMANA HEALTH PLAN, INC.
ACTUARIAL MEMORANDUM
POLICY FORM SERIES CO-71130-POS & CO-71129

A. Summary

1. Purpose

We respectfully submit for your consideration the enclosed premium rates for use with the above captioned policy series. This actuarial memorandum was created and formatted pursuant to Colorado Regulation 4-2-11, Section 6.

This filing has been prepared for the purpose of certifying that the anticipated loss ratio of this product meets the minimum requirement of this state, assuring that rates are reasonable in relation to the benefits provided, as well as demonstrating rates are not excessive, inadequate, or unfairly discriminatory. It is not intended to be used for any other purpose.

2. Requested Rate Action

This is a new product; therefore there is no requested rate action.

3. Marketing Methods

The policy will be marketed by general agents, brokers, wholesale arrangements, and by Humana employees through various campaigns geared directly to consumers. A suite of plans included in policy form series, CO-71129 will be offered both on and off the exchange. The remaining plans will be offered off exchange exclusively.

Previously approved form series under the Humana Health Plan entity, CO-71037-POS, will be discontinued beginning 1/1/2014. Members will receive necessary notification and the opportunity to purchase any of the plans included in this filing.

4. Premium Classifications

Premium rates vary by combination of age (as of issue for new business and attained age for renewals), tobacco usage, geographic area, and family composition. These associated factors can be found in the attached rate manual.

5. Product Description

This is an Individual Major Medical plan sold and renewed to individuals and families. The rates under policy form series, CO-71130-POS, support a Point-of-Service plan provided through a dual entity POS contract with Humana Health Plan, Inc. and Humana Insurance Company. The dual entity POS contract communicates both network and non-network benefits to a member in a single policy. The member has open access to network HMO providers as referrals are not required. The network supporting this product is a combination of both HMO and PPO network providers, affording members with access to a larger provider network.

The rates under policy form series, CO-71129, support a Health Maintenance Organization plan provided through an HMO contract with Humana Health Plan, Inc. Indemnity benefits on these policy series are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred.

The plans under policy series CO-71120-POS include our embedded Wellness & Rewards Program, HumanaVitality. The premium impact of this embedded benefit is 1%, approximately $2.40 PMPM. Pursuant to § 10-16-136(3.7), C.R.S., Humana received national accreditation from the National Committee of Quality

Assurance on September 11, 2012 (attached certification and letter under Supporting Documents Tab). Furthermore, please see the Supporting Documents Tab for documentation demonstrating that the wellness program is scientifically proven to improve health (Regulation 4-2-11 7.B).

All non-grandfathered plans must cover the essential health benefits package in 2014. The specifics of the essential health benefits are contained within the benchmark plan selected in each state. There are 3 high level categories of benefits that are considered from a pricing perspective for the individual market: (1) maternity, (2) behavioral services and (3) other state-specific services. For the pricing impact of these 3 benefits, please see section J below.

The following PPACA benefits have been implemented in all of our non-grandfathered business,

- Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
- Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
- Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
- Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
- Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
- Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
- Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
- Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
- Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
- Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

A summary of key benefit can be found in the rate manual, along with the rating factors associated with the plans; the policy form should be consulted for specific benefit provisions.

6. Age Basis

Premiums will be calculated using age at issue for new business and attained age for renewing business.

B. Assumption or Acquisition

All plan designs have been developed internally and are not part of an assumption or acquisition.

C. Rating Period

The effective date of the rating period is January 1, 2014 for all plan designs. Rates are effective until 1/1/2015, at which point members issued during 2014 will have their rate potentially modified.

D. Underwriting

All membership is intended to be issued without underwriting.

E. Effect of Law Changes

This rate filing was prepared to support the law changes mandated as a result of the Affordable Care Act. A detailed description of the impacts can be found in section J.

F. Rate History

CO-71129 and CO-71130-POS are new policy form series, therefore no rate history can be provided.

G. Coordination of Benefits

Coordination of benefits data is included in the loss ratio calculation.

H. Relation of Benefits to Premium

Below is a summary of the retention estimate used for pricing this product. Note that investment income is not included, as it is not expected to be a material contribution to the profitability of this product.

Expense Category	**% of Premium**
Broker & Sales Commissions	4.40%
Quality Expenses	1.20%
Clinical & Network Operations	1.90%
IT Expenses	1.00%
Customer Service & Account Installation	1.60%
Corporate Administration	2.40%
Individual Products Administration	2.70%
Direct Response, Marketing, & Agency Management	1.60%
State Premium Tax	0.30%
Health Insurer Annual Fee	1.40%
Exchange Fee	0.90%
Other Misc Taxes & Assessments	0.10%
Income Tax	2.50%
Total Administrative Expense	**21.90%**
Loss Ratio	75.00%
Post-Tax Risk Margin/Profit	3.10%

I. Provision for Profit and Contingencies

The provision for profit and contingencies is 3.1% post-FIT. Because we do not anticipate holding policy reserves on this business, investment income only is obtained by returns on unearned premium reserves and reserves for incurred but not reported claims. We do not know the timing of when we will receive the advanced premium tax credits from the federal government. We anticipate that the unearned premium reserve may be offset by payment delays from the federal government. Therefore, we expect investment income to be a negligible source of revenue for this product line.

J. Complete Explanation as to How the Proposed Rates were Determined

The original premiums for this policy form series were developed using experience from existing policy forms by adjusting for benefit differences, expense differences and any other rating differences. Premium rates were developed so that the ratio of claims to premium would produce a reasonable lifetime loss ratio, not less than any minimum required in this state.

The form series, CO-71037 was used as the basis for the pricing for 2014. This represents the current new business product available for purchase throughout the state. The overall rates were adjusted for additional essential health benefits, trend between the 10/1/2013 premium basis and 1/1/2014, guaranteed issue, expected network improvements, differences in allowed rating factors, 10/1/2013 pricing adequacy, marginal taxes & fees, and the expected net impact of reinsurance and risk adjustment.

Details are as follows:

- Essential Health Benefits
  - Maternity
    - Estimated at 0.0% impact. This benefit is already covered in our individual plans today.
  - Behavioral Services
    - Estimated at 0.6% impact. This estimate was produced using small group allowed claims as a percentage of overall claims and adjusting the incidence rate for the expected FPL mix.
  - Other Misc
    - Other essential health benefit impacts estimated at 0.6%.
- Trend
  - 1.3% impact to go from the midpoint of the 10/1/2013 rating period to 1/1/2014. Please see the attached exhibit.
- Guaranteed Issue
  - Estimated 62.0% impact. Based on comparison of our own small group claims from the 2-50 market, consultant estimates, and an estimate of the total market mix between previously underwritten individuals and newly issued.
- Network Improvements
  - We were able to achieve significant estimated savings in Denver and Colorado Springs by changing from the current POS network to new HMO networks. Savings are reflected in the area factors and value at approximately -27.8%. (For new business on exchange only.)
- Allowed Rating Factor Differences
  - Estimated 4.0% impact for the removal of durational rating.
  - Estimated 8.3% impact for the removal of underwriting rate ups.
  - Estimated 0.7% impact for capping the number of dependents at 3
- Current Pricing Adequacy Adjustment
  - Estimated -4.6% impact for adequacy of current rates. Developed using projected 2013 loss ratio compared to target loss ratio, adjusted for rate actions through the year to determine 10/1/2013 adequacy.
- Marginal Taxes & Fees
  - New federal health insurer annual fee is estimated at 2.1% of premium (this includes the gross up for this fee not being tax deductible).
  - Exchange user fee is estimated at 0.9% of premium in total.
- Net Impact of Reinsurance and Risk Adjustment
  - Total adjustment for reinsurance payment & risk adjustment payment is estimated at -18.7%

K. Index Rate

Please see the attached exhibit, Exhibit C – CO HHP Base Rate Development.

L. Trend: Cost & Utilization

Annual Cost Trend: 3.1%
Annual Utilization Trend: 6.2%

The cost trend captures pure unit cost changes from midpoint 2012 to midpoint 2014, calculated using the same basket of services each period, due to price/contract negotiations and provider distribution changes.

Inpatient Hospital, Outpatient Hospital, Professional, Capitation and Other Medical cost trends are developed based on historical area specific cost trends from Humana's Individual Commercial block of business data. Future cost trends are developed based on expected changes in Humana's Commercial contracts. Pharmacy cost trends are developed based on historical brand, generic, and specialty drug trends from Humana's Commercial data. Future cost trends are developed based on expected changes in these pharmacy contracts. These contractual impacts will be applicable to all members regardless of risk class.

Utilization trend:

Using Humana's Trend Quantification and Projection model, a baseline utilization trend is developed using Humana's Individual Commercial block of business historical medical claims data from 2008 - 2012. The historical baseline utilization trend is developed by removing all known impacts to utilization net trend such as demographics, geography, duration, customer changes, benefit changes, new health technologies, utilization management initiatives, and changes in pertinent days. An economic regression model, based on consumer sentiment, personal disposable income, hospital construction, and high-tech medical equipment spend, is then fit to this historical baseline utilization data to project the future block of business baseline utilization trend for 2013 and 2014.

A midpoint to midpoint methodology is applied to determine the applicable baseline utilization trend, which incorporates 2012q3 and 2012q4 actual results at the state and legal entity level with the block of business baseline utilization trend for 2013 and 2014. This results in baseline utilization trends that vary at the state and legal entity level.

Other components are added to the baseline utilization trend to develop the total utilization trend provided. These include the following:

- Pertinent days – Captures changes in the calendar, recognizing that health care utilization varies by day of the week and reporting periods contain varying weekday mix and count. This impact is developed through the use of an external consultant's model which is uploaded with Humana's Commercial claims data.

- New Health Technologies – Captures the impact of new health technologies and procedures. An external consulting firm researches new technologies and develops per member per month impacts. These impacts are customized to Humana's Commercial business based on membership and coverage policy.

- Management Initiatives – Captures savings for Humana initiatives designed to bend trend by managing utilization, such as case management, disease management, and nurse programs. These initiatives are evaluated by an internal actuarial organization tasked with evaluating the effectiveness of the initiatives. Evaluations are done through a collaborative effort involving clinical and other operational areas. Projected savings are calculated by determining prospective changes to impacted metric values, which are determined by analyzing historical metric values as well as through discussions with clinical and operational areas. Savings are reviewed with leadership to ensure appropriateness of assumptions.

This describes the development of the core utilization trend. All impacts from healthcare reform have been removed and are included in the "Population Risk/Morbidity" and "Other" adjustments from URR Worksheet 1 to prevent double counting of any impacts.

For additional detail, please see the attached trend exhibits, Exhibit B.

M. Credibility

To credibility adjust this block of business, a credibility manual consisting of slight modifications to 2014 market projections was utilized. Source data utilized for the credibility manual calculation includes Colorado Humana Health Plan, Inc. utilization per 1000 that mirrors the 2014 projected experience, adjusting to reflect the overall credibility of the block of business that we apply in pricing to ensure adequacy of rates.

The average cost per service is driven by the Colorado Humana Health Plan, Inc. 2014 projected experience in order to maintain representation of the provider contracts and distribution mix represented in the allowed claim derivation, also adjusted to reflect the credibility of the block of business to ensure pricing adequacy.

The state of Colorado has mandated a level of 24,000 member months for full credibility. Per that mandate, our credibility weight methodology has been adjusted to reflect utilizing the following equation: square root(member months in experience period/24000). To account for the presence of Colorado Humana Health Plan, Inc. experience in the credibility manual, the credibility level afore mentioned has been reduced by a factor of the expected 2014 membership relative to nationwide.

We do not expect to have services in the projection period provided under a capitation arrangement.

N. Data Requirements

Please see the attached past and future projection exhibit, Exhibit A.

O. Side-by-Side Comparison

The proposed rates on policy form series CO-71129 & CO-71130-POS are new. Therefore, there is no comparison between current rates and proposed rates.

P. Benefits Ratio Projections

Benefit projection ratio is projected to be 75%. This includes the effects of reinsurance and risk adjustment. Please see projection exhibit for details. For your reference, Actuarial Justification has been provided via attachment, 2014 CO HHP Justification of Benefit Ratio.

Q. Other Factors

See attached rate manual.

R. Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify that this rate filing adheres to the laws of this state, to the best of my knowledge. I further certify that the assumptions used to develop rates are reasonable, that they have been set with an understanding of the business plan for this form series, and that they produce rates that are not excessive, inadequate or unfairly discriminatory.

Stephen Arnhold, FSA, MAAA
Actuarial Director, Individual Product Segment
June 19, 2013

Exhibit A-1

Colorado - Humana Health Plan
Past & Projected Future Experience for all Non-Grandfathered Business
Includes Requested Rate Change

Year	Mbr Months	Ave Covered Lives	Policies	Premium	Colorado On Rate Premium	Incurred Claims	Estimated IBNR Claims	Expected Claims	Number of Claims	LR	ELR	A/E	Average Duration	
2012	91,997	7,666	4,259	12,811,963	26,578,519	6,856,120	665,078	7,545,229	37,054	53.5%	58.9%	0.909	5.9	
2013	118,971	9,914	5,508	17,736,627	31,165,910	10,715,954	829,961	12,845,748	7,157	60.4%	72.4%	0.834	14.0	<- Partial Year of Actuals
2014	450,386	37,532	20,851	105,818,083	105,818,083	79,363,562	-	79,363,562	-	75.0%	75.0%	1.000	6.1	
2015	293,706	24,475	13,597	82,471,568	69,006,127	61,853,676	-	61,853,676	-	75.0%	75.0%	1.000	18.1	
2016	191,531	15,961	8,867	61,264,316	45,000,300	45,948,237	-	45,948,237	-	75.0%	75.0%	1.000	30.1	
2017	124,902	10,408	5,782	45,551,179	29,345,612	34,163,385	-	34,163,385	-	75.0%	75.0%	1.000	42.1	
2018	81,451	6,788	3,771	32,904,658	19,136,871	24,678,494	-	24,678,494	-	75.0%	75.0%	1.000	54.1	
2019	53,116	4,426	2,459	23,769,232	12,479,543	17,826,924	-	17,826,924	-	75.0%	75.0%	1.000	66.1	
2020	34,638	2,886	1,604	17,170,103	8,138,164	12,877,577	-	12,877,577	-	75.0%	75.0%	1.000	78.1	
2021	22,588	1,882	1,046	12,403,112	5,307,063	9,302,334	-	9,302,334	-	75.0%	75.0%	1.000	90.1	
2022	14,730	1,228	682	8,959,596	3,460,844	6,719,697	-	6,719,697	-	75.0%	75.0%	1.000	102.1	
2023	9,606	800	445	6,472,114	2,256,887	4,854,086	-	4,854,086	-	75.0%	75.0%	1.000	114.1	
2024	6,264	522	290	4,675,240	1,471,762	3,506,430	-	3,506,430	-	75.0%	75.0%	1.000	126.1	
2025	4,085	340	189	3,377,238	959,766	2,532,929	-	2,532,929	-	75.0%	75.0%	1.000	138.1	

	PV Premium	PV Claims	PV Expected Claims	LR	ELR	A/E
Actuals	17,486,565	9,344,938	10,409,940	53.4%	59.5%	0.898
Projected	378,084,046	281,419,858	283,421,263	74.4%	75.0%	0.993
Total	395,570,611	290,764,796	293,831,204	73.5%	74.3%	0.990

Present Value as of 01/01/2014 at 4.0% interest.

Assumptions

General

- Projections are exclusive of rebates under the federal minimum loss ratio rules
- Incurred claims column is net of reinsurance and risk adjustment
- Incurred claims adjusted for benefit seasonality
- Average duration is in months

Pre-2014 Effective Cohort

- Contains actuals through 02/28/2013 for all non-grandfathered business
- Lapse 2.5% per month
- Expected loss ratio based on durational underwriting curve w/ a 78.5% lifetime loss ratio.
- Policy reserves are not included
- Claims Trend 12.1%
- Attained Age 2.0%
- No projected sales included after 02/28/2013
- Projected to begin terminate on 12/31/2013, though model assumes all on 12/31 for simplification

Post-2014 Effective Cohort

- Claims Trend 8.6%
- Assumes 46,957 members sold effective in 2014
- Lapse 3.5% per month
- Loss ratio is expected to be 75.0%, with no durational variation
- Initial PMPM Premium: $235

Exhibit A-2

Colorado - Humana Health Plan
Past & Projected Future Experience for all Non-Grandfathered Business
Excludes Requested Rate Change

Year	Mbr Months	Ave Covered Lives	Policies	Premium	Colorado On Rate Premium	Incurred Claims	Estimated IBNR Claims	Expected Claims	Number of Claims	LR	ELR	A/E	Average Duration	
2012	91,997	7,666	4,259	12,811,963	26,578,519	6,856,120	665,078	7,545,229	37,054	53.5%	58.9%	0.909	5.9	
2013	118,971	9,914	5,508	17,736,627	31,165,910	10,715,954	829,961	12,845,748	7,157	60.4%	72.4%	0.834	14.0	<- Partial Year of Actuals
2014	450,386	37,532	20,851	105,818,083	105,818,083	79,363,562	-	79,363,562	-	75.0%	75.0%	1.000	6.1	
2015	293,706	24,475	13,597	82,471,568	69,006,127	61,853,676	-	61,853,676	-	75.0%	75.0%	1.000	18.1	
2016	191,531	15,961	8,867	61,264,316	45,000,300	45,948,237	-	45,948,237	-	75.0%	75.0%	1.000	30.1	
2017	124,902	10,408	5,782	45,551,179	29,345,612	34,163,385	-	34,163,385	-	75.0%	75.0%	1.000	42.1	
2018	81,451	6,788	3,771	32,904,658	19,136,871	24,678,494	-	24,678,494	-	75.0%	75.0%	1.000	54.1	
2019	53,116	4,426	2,459	23,769,232	12,479,543	17,826,924	-	17,826,924	-	75.0%	75.0%	1.000	66.1	
2020	34,638	2,886	1,604	17,170,103	8,138,164	12,877,577	-	12,877,577	-	75.0%	75.0%	1.000	78.1	
2021	22,588	1,882	1,046	12,403,112	5,307,063	9,302,334	-	9,302,334	-	75.0%	75.0%	1.000	90.1	
2022	14,730	1,228	682	8,959,596	3,460,844	6,719,697	-	6,719,697	-	75.0%	75.0%	1.000	102.1	
2023	9,606	800	445	6,472,114	2,256,887	4,854,086	-	4,854,086	-	75.0%	75.0%	1.000	114.1	
2024	6,264	522	290	4,675,240	1,471,762	3,506,430	-	3,506,430	-	75.0%	75.0%	1.000	126.1	
2025	4,085	340	189	3,377,238	959,766	2,532,929	-	2,532,929	-	75.0%	75.0%	1.000	138.1	

	PV Premium	PV Claims	PV Expected Claims	LR	ELR	A/E
Actuals	17,486,565	9,344,938	10,409,940	53.4%	59.5%	0.898
Projected	378,084,046	281,419,858	283,421,263	74.4%	75.0%	0.993
Total	395,570,611	290,764,796	293,831,204	73.5%	74.3%	0.990

Present Value as of 01/01/2014 at 4.0% interest.

Assumptions

General

- Projections are exclusive of rebates under the federal minimum loss ratio rules
- Incurred claims column is net of reinsurance and risk adjustment
- Incurred claims adjusted for benefit seasonality
- Average duration is in months

Pre-2014 Effective Cohort

- Contains actuals through 02/28/2013 for all non-grandfathered business
- Lapse 2.5% per month
- Expected loss ratio based on durational underwriting curve w/ a 78.5% lifetime loss ratio.
- Policy reserves are not included
- Claims Trend 12.1%
- Attained Age 2.0%
- No projected sales included after 02/28/2013
- Projected to begin terminate on 12/31/2013, though model assumes all on 12/31 for simplification

Post-2014 Effective Cohort

- Claims Trend 8.6%
- Assumes 46,957 members sold effective in 2014
- Lapse 3.5% per month
- Loss ratio is expected to be 75.0%, with no durational variation
- Initial PMPM Premium: $235

Exhibit B1: HumanaOne Trend Estimate

Service Month	End of Month Member Count	Paid Medical Claims	IBNR Medical Reserves	Total Incurred Medical Claims	Paid Rx Claims	Total Incurred Claims	Raw PMPM Claims (A)	Relative Exp LR (B)	Relative Age Factor (C)	Relative Area Factor (D)	Relative Plan Factor (E)	Adj PMPM Clms (A)/(B*C*D*E)	YoY Trend Raw	YoY Trend Adjusted
4/1/2010	9	0	0	0	0	0								
5/1/2010	169	1,629	0	1,630	1	1,631								
6/1/2010	872	12,034	1	12,035	20	12,055								
7/1/2010	1,381	31,415	3	31,417	88	31,505								
8/1/2010	1,859	65,103	6	65,109	1,367	66,476								
9/1/2010	2,685	92,028	9	92,036	1,438	93,474								
10/1/2010	3,883	225,045	40	225,086	6,574	231,659								
11/1/2010	4,683	265,071	48	265,119	9,032	274,151								
12/1/2010	6,480	285,514	59	285,573	8,108	293,681								
1/1/2011	6,722	272,337	76	272,413	5,810	278,223								
2/1/2011	7,373	380,852	119	380,971	10,685	391,656								
3/1/2011	8,632	880,832	344	881,176	14,449	895,625	57.44	1.000	1.000	1.000	1.000	57.44		
4/1/2011	9,547	836,449	420	836,869	11,516	848,386	62.97	1.013	1.003	0.999	1.001	61.95		
5/1/2011	10,795	767,144	531	767,675	12,907	780,582	64.66	1.026	1.006	0.998	1.001	62.70		
6/1/2011	11,687	806,486	590	807,077	13,230	820,307	66.10	1.040	1.010	0.998	1.001	63.04		
7/1/2011	12,300	882,364	769	883,133	68,851	951,984	68.40	1.053	1.013	0.997	1.001	64.29		
8/1/2011	13,179	869,881	831	870,712	22,837	893,549	68.93	1.065	1.014	0.996	1.001	64.02		
9/1/2011	13,937	1,481,144	1,742	1,482,886	25,752	1,508,638	74.79	1.076	1.016	0.996	1.001	68.63		
10/1/2011	14,600	1,375,224	2,100	1,377,324	46,836	1,424,160	78.05	1.083	1.017	0.995	0.999	71.22		
11/1/2011	15,340	1,802,167	3,187	1,805,355	40,167	1,845,522	83.71	1.090	1.019	0.995	0.998	75.97		
12/1/2011	16,623	1,568,892	2,823	1,571,715	61,071	1,632,785	87.20	1.096	1.020	0.994	0.996	78.74		
1/1/2012	17,472	1,098,760	4,530	1,103,290	11,913	1,115,202	86.53	1.101	1.022	0.994	0.994	77.85		
2/1/2012	18,482	1,268,737	5,207	1,273,944	19,762	1,293,706	86.17	1.106	1.023	0.994	0.992	77.29		
3/1/2012	19,827	1,411,861	12,015	1,423,875	23,350	1,447,225	83.79	1.111	1.024	0.994	0.990	74.94	45.9%	30.5%
4/1/2012	20,487	1,477,002	11,713	1,488,715	37,888	1,526,604	82.50	1.115	1.025	0.994	0.988	73.58	31.0%	18.8%
5/1/2012	21,073	2,512,138	25,283	2,537,422	56,437	2,593,859	87.45	1.120	1.026	0.993	0.985	77.74	35.2%	24.0%
6/1/2012	21,900	2,792,827	31,784	2,824,611	54,627	2,879,238	93.13	1.125	1.026	0.993	0.983	82.54	40.9%	30.9%
7/1/2012	22,287	1,814,652	32,871	1,847,523	53,587	1,901,109	93.22	1.131	1.028	0.993	0.981	82.30	36.3%	28.0%
8/1/2012	22,919	3,397,960	85,093	3,483,053	67,982	3,551,035	101.00	1.136	1.029	0.993	0.979	88.80	46.5%	38.7%
9/1/2012	23,635	2,214,939	131,522	2,346,462	67,186	2,413,648	100.68	1.142	1.031	0.993	0.977	88.12	34.6%	28.4%
10/1/2012	23,591	2,439,961	164,078	2,604,040	105,153	2,709,193	102.24	1.148	1.033	0.993	0.975	89.06	31.0%	25.0%
11/1/2012	23,763	2,499,093	307,018	2,806,111	103,033	2,909,144	103.04	1.155	1.035	0.993	0.972	89.32	23.1%	17.6%
12/1/2012	24,175	2,216,203	503,082	2,719,285	118,887	2,838,173	104.69	1.162	1.037	0.993	0.970	90.27	20.1%	14.6%
1/1/2013	23,942	1,244,546	561,006	1,805,552	47,439	1,852,990	104.92	1.169	1.039	0.992	0.968	89.93	21.2%	15.5%
2/1/2013	24,182	485,465	1,153,358	1,638,823	50,464	1,689,287	104.17	1.177	1.041	0.992	0.965	88.76	20.9%	14.8%
											Yellow Cell Average		34.2%	25.5%

Notes:
(A) Data shown is paids through February
(B) Rx claims are assumed complete
(C) Only includes non-grandfathered business on both HIC & HHP

Exhibit B2

Annual Trend Estimates by Service Category

		Cost					Utilization				
Quarter	Weight	Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Prescription Drug	Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Prescription Drug
2012q4	4%	0.0%	4.3%	2.1%	0.8%	9.9%	-1.3%	92.9%	126.3%	557.0%	66.8%
2013q1	8%	3.5%	4.5%	0.8%	0.8%	9.5%	-1.8%	6.2%	0.5%	16.5%	2.8%
2013q2	11%	3.5%	4.4%	0.8%	0.7%	9.5%	-1.8%	5.7%	2.2%	8.4%	2.9%
2013q3	14%	3.8%	4.4%	0.8%	0.8%	9.5%	-1.0%	3.5%	2.3%	0.9%	3.0%
2013q4	13%	3.7%	4.3%	0.9%	0.8%	9.4%	-0.9%	5.1%	0.7%	10.7%	1.7%
2014q1	18%	3.4%	4.0%	1.0%	1.0%	9.1%	0.3%	1.6%	0.9%	2.3%	6.5%
2014q2	31%	3.6%	4.1%	1.0%	1.0%	9.1%	2.0%	3.1%	0.9%	8.5%	5.8%
	Average	3.4%	4.2%	1.0%	0.9%	9.3%	0.0%	7.4%	6.4%	29.8%	7.0%
	Weights	49.81	100.18	121.99	6.79	24.07	53.25	108.77	124.44	6.91	28.76
	Total	3.1%					6.2%				

Notes:

Includes non-grandfathered HHP membership only.

Based on internal trend model

Matches what was used in the URR

Supporting Exhibit: Rate Review Detail (SERFF Requirement)

The purpose of this document is to explain the assumptions used when calculating fields for the rate review detail window in SERFF.

Requested Rate Change Information

Change Period:	Annual		
Member Months[1]:	91,997		
Benefit Change:	None		
	Min[2]	Max[2]	Weighted Avg[2]
Percent Rate Change Requested:	0.0%	0.0%	0.0%

Prior Rate

Total Earned Premium[3]:	$0		
Total Incurred Claims[3]:	$0		
	Min[4]	Max[5]	Weighted Avg[6]
Annual $:	0	0	0

Requested Rate

Projected Earned Premium[7]:	$132,385,931		
Projected Incurred Claims[7]:	$99,249,732		
	Min[8]	Max[9]	Weighted Avg[10]
Annual $:	84	1,332	235

Notes

(1) Based on experience from January 2012 through December 2012.
(2) Not applicable, this is the initial filing.
(3) Not applicable, this is the initial filing.
(4) Not applicable, this is the initial filing.
(5) Not applicable, this is the initial filing.
(6) Not applicable, this is the initial filing.
(7) Projected over calendar year 2014, including policy reserves.
(8) The Minimum Annual $ is the lowest possible monthly rate per member for standard benefits effective January 1, 2014.
(9) The Maximum Annual $ is the highest possible monthly rate per member for standard benefits effective January 1, 2014.
(10) The Weighted Average Annual $ is the pmpm projected premium on a January 1, 2014 basis.

Please complete the |Rate Sample| tab with premiums for a 40 year old, non-smoker from your richest and leanest plans and provide the following information

- Plan Name
- Metal Tier
- Rating Area
- Network

Plan Name	Metal Tier	Rating Area	Network	Premium
Humana Connect Basic 6350/6350 Plan	Catastrophic	1	POS	
Humana Connect Bronze 6300/6300 Plan	Bronze	1	POS	
Humana Connect Silver 4600/6300 Plan	Silver	1	POS	
Humana Connect Gold 2500/3500 Plan	Gold	1	POS	
Humana Connect Platinum 1000/1500 Plan	Platinum	1	POS	
Humana Connect Bronze 4900/6400 Plan	Bronze	1	POS	
Humana Connect Silver 3650/3650 Plan	Silver	1	POS	
Humana Preferred Basic 6350/6350 Plan	Catastrophic	1	POS	293.40
Humana Preferred Bronze 4900/6400 Plan	Bronze	1	POS	396.28
Humana Preferred Silver 4250/6250 Plan	Silver	1	POS	414.42
Humana Preferred Bronze 6300/6300 Plan	Bronze	1	POS	352.25
Humana Preferred Silver 3650/3650 Plan	Silver	1	POS	407.28
Humana Connect Basic 6350/6350 Plan	Catastrophic	2	HMOx	169.67
Humana Connect Bronze 6300/6300 Plan	Bronze	2	HMOx	213.54
Humana Connect Silver 4600/6300 Plan	Silver	2	HMOx	242.16
Humana Connect Gold 2500/3500 Plan	Gold	2	HMOx	276.21
Humana Connect Platinum 1000/1500 Plan	Platinum	2	HMOx	311.40
Humana Connect Bronze 4900/6400 Plan	Bronze	2	HMOx	230.17
Humana Connect Silver 3650/3650 Plan	Silver	2	HMOx	245.65
Humana Preferred Basic 6350/6350 Plan	Catastrophic	2	HMOx	
Humana Preferred Bronze 4900/6400 Plan	Bronze	2	HMOx	
Humana Preferred Silver 4250/6250 Plan	Silver	2	HMOx	
Humana Preferred Bronze 6300/6300 Plan	Bronze	2	HMOx	
Humana Preferred Silver 3650/3650 Plan	Silver	2	HMOx	
Humana Connect Basic 6350/6350 Plan	Catastrophic	2	POS	
Humana Connect Bronze 6300/6300 Plan	Bronze	2	POS	
Humana Connect Silver 4600/6300 Plan	Silver	2	POS	
Humana Connect Gold 2500/3500 Plan	Gold	2	POS	
Humana Connect Platinum 1000/1500 Plan	Platinum	2	POS	
Humana Connect Bronze 4900/6400 Plan	Bronze	2	POS	
Humana Connect Silver 3650/3650 Plan	Silver	2	POS	
Humana Preferred Basic 6350/6350 Plan	Catastrophic	2	POS	242.15
Humana Preferred Bronze 4900/6400 Plan	Bronze	2	POS	327.06
Humana Preferred Silver 4250/6250 Plan	Silver	2	POS	342.03
Humana Preferred Bronze 6300/6300 Plan	Bronze	2	POS	290.72
Humana Preferred Silver 3650/3650 Plan	Silver	2	POS	336.14
Humana Connect Basic 6350/6350 Plan	Catastrophic	3	HMOx	175.43
Humana Connect Bronze 6300/6300 Plan	Bronze	3	HMOx	220.78
Humana Connect Silver 4600/6300 Plan	Silver	3	HMOx	250.38
Humana Connect Gold 2500/3500 Plan	Gold	3	HMOx	285.58
Humana Connect Platinum 1000/1500 Plan	Platinum	3	HMOx	321.96
Humana Connect Bronze 4900/6400 Plan	Bronze	3	HMOx	237.97
Humana Connect Silver 3650/3650 Plan	Silver	3	HMOx	253.98
Humana Preferred Basic 6350/6350 Plan	Catastrophic	3	HMOx	
Humana Preferred Bronze 4900/6400 Plan	Bronze	3	HMOx	
Humana Preferred Silver 4250/6250 Plan	Silver	3	HMOx	
Humana Preferred Bronze 6300/6300 Plan	Bronze	3	HMOx	
Humana Preferred Silver 3650/3650 Plan	Silver	3	POS	
Humana Connect Basic 6350/6350 Plan	Catastrophic	3	POS	
Humana Connect Bronze 6300/6300 Plan	Bronze	3	POS	
Humana Connect Silver 4600/6300 Plan	Silver	3	POS	
Humana Connect Gold 2500/3500 Plan	Gold	3	POS	
Humana Connect Platinum 1000/1500 Plan	Platinum	3	POS	
Humana Connect Bronze 4900/6400 Plan	Bronze	3	POS	
Humana Connect Silver 3650/3650 Plan	Silver	3	POS	
Humana Preferred Basic 6350/6350 Plan	Catastrophic	3	POS	255.90
Humana Preferred Bronze 4900/6400 Plan	Bronze	3	POS	345.63
Humana Preferred Silver 4250/6250 Plan	Silver	3	POS	361.45
Humana Preferred Bronze 6300/6300 Plan	Bronze	3	POS	307.23
Humana Preferred Silver 3650/3650 Plan	Silver	3	POS	355.22

State of Colorado

HUMANA HEALTH PLAN, INC.
ACTUARIAL JUSTIFICATION OF BENEFIT RATIO

A. Scope and Purpose

The purpose of this document is to establish additional support that the rates proposed within this rate filing are reasonable in relation to the benefits provided; are not excessive, inadequate, or unfairly discriminatory; and comply with all applicable market rating rules set forth by the Federal government and the state of Colorado.

The State of Colorado in PPACA Rate Filing Procedures for Colorado, Actuarial Memorandum instructions Section G. Benefit Ratio Guidelines, specifies a recommended benefit ratio guideline of 80% for Comprehensive Major Medical (Individual). This document states that any benefit ratio below 80% must be actuarially justified. This document provides actuarial justification for the filed benefit ratio of 75%, calculated as 1- (sum of percentage administrative expense percentage, taxes & fees, and profit & risk margin).

The Actuarial Memorandum supports a loss ratio of 80% using the Federally prescribed methodology. Since compliance with the Federal methodology is already supported, this document does not additionally address the Federal MLR calculation.

B. Expense Development Methodology

Expenses levels are based on the January 31, 2013 Humana individual medical long term forecast of expenses. This forecast incorporates 2012 actuals as a baseline and 2013 budgeted expenses at a national level to project 2014 expenses. These expenses are shown as a percentage of premium in Attachment 1. The 2014 forecast assumes a significant increase in national membership as a result of participation in a number of state exchanges. We assume a 66% increase in our member months from 2013 to 2014. We also assume a 42% increase in premium per member per month (pmpm). Both the increase in membership and pmpm premium are used to leverage a decrease in fixed expenses as a percentage of premium. The forecast itself is prepared at a very detailed level with approximately 50 primary cost centers which each have numerous sub-categories. These have been summarized in the following categories which are outlined in the Actuarial Memorandum, shown in Attachment 1, and described below with anticipated changes from 2013 to 2014:

1. Broker and Sales Commissions

   Broker and Sales commissions are projected to decrease from 6.6% to 4.4%. This reduction is projected to occur as a result of placing some business directly on exchange. We expect to have some of our exchange business placed with broker assistance and Federal Regulations require that business to be compensated with the same commission rate as off exchange business. We also expect to reduce commission rates due to higher pmpm premium and improved placement rates without underwriting.

2. Quality Expenses

   We are forecasting a reduction from 2.2% of premium to 1.2% of premium based on fixed expense leveraging and improved scale in our well-being programs.

3. Clinical and Networks Operations

   We expect clinical expenses to increase from our historic levels to levels we experience in small business as the underwritten population is replaced by a higher morbidity population. This increase is more than offset by a decrease in network operations the efforts to contract networks for the exchanges wind down. Clinical is not subject to fixed expense leveraging, but the network operations are. The net impact is a decrease from 2.8% to 1.9% of premium.

4. IT Expenses

   Our IT expenses increased significantly in 2013 as a result of building PPACA compliant applications for both on and off exchange products. This rate of expenditure is expected to drop significantly in 2014 as this build work is completed and there is further fixed expense leveraging on some of the components. The net impact is expected to be a decrease from 2.7% to 1.0% of premium.

5. Customer Service and Account Installation

   This category includes claims administration. This category is experiencing a significant increase in 2013 as customer facing areas get prepared for exchange membership. We need to have several of these areas fully staffed in anticipation of the open enrollment period and there will be no revenue until 2014 to offset those costs. Since open enrollment and exchanges are new concepts to our customers and prospects, we expect unusually high call volume during the open enrollment period. Expenses are expected to decrease from 3.0% of premium in 2013 to 1.6% of premium in 2014 as the start-up effort winds down and from expense leveraging of the additional revenue. We are also eliminating some of the claims positions associated with investigation of underwritten policies in 2014.

6. Corporate Administration

   This category includes legal, finance, human resources, etc. These functions support our individual business and have been contributing to the interpretation and implementation of PPACA. The expenses for these functions will decrease from 4.2% of premium to 2.4% of premium mostly as a result of fixed expense leveraging.

7. Individual Administration

   This includes management of the line of business, actuarial, the project management office and underwriting. We have an increase in 2013 from the project management office staffing to an increased level for reform. In 2014, we expect a decrease form 6.3% to 2.7% of premium. The reduction is driven by the elimination of underwriting positions, the wind down of the PPACA build efforts and fixed expense leveraging.

8. Direct Response, Marketing and Agency Management

   We are experiencing an increase in 2013 expenses related to educational and marketing material development, including electronic media. We do not expect to significantly increase direct marketing in the open enrollment period as we expect our resources to be fully engaged. We do have an expansion of our call center staffing planned to handle increased call volume during the open enrollment period. We expect a decrease in expenses from 3.0% to 1.6% as the environment stabilizes in 2014 and we experience fixed expense leveraging.

9. Total Administrative Costs

   Total administrative costs were 27.6% in 2012 and 30.8% in 2013 before we expect a drop to 16.8% in 2014. Although our individual line of business is growing, it is still relatively small and we have not been able to manage our expenses to a level where we can operate profitably since PPACA established minimum MLR requirement. We did have significant reductions in many categories and in aggregate in 2011 in preparation for MLR rebates, but those gains were negated in 2012 and 2013 by the expenses of preparing for PPACA implementation.

10. State Premium Tax

    This category include assessments and fees and is held constant at our Colorado actual level of 0.3% of premium for this legal entity.

11. Health Insurer Annual Fee

    This is the non-deductible fee leveraged under PPACA on all health insurers. The percentage is projected based on Humana's share of the national health insurance market and allocated back to lines of business as 1.4% of premium.

12. Exchange Fee

    This is a Colorado specific calculation based on the percentage of business we expect on and off exchange in this legal entity.

13. Misc Taxes

This is the per member per year fee to fund research levied by PPACA.

14. Income Taxes

This category includes Federal income tax and the tax on the non-deductible health insurer annual fee. In 2012 and 2013 we expect a negative adjustment from Federal income taxes as the individual medical product line is unprofitable. This results in a reduction in expenses of 0.4% for 2012 and is expected to offset 1.7% of expenses in 2013. We expect a return to profitability with significant reductions in expenses in 2014. Combined with the addition of the tax on the health insurer annual fee, we expect our income taxes to increase to 2.5% in 2014.

15. Post Tax Profit & Risk Margin

We are pricing this product for a 3.1% post tax profit and risk margin in 2014. We believe this is a reasonable level for a number of reasons. We have experienced a loss over the last several years and need to price for a sustainable business. This result is based on assumptions around business and revenue growth that may not be realized. This result is based on product pricing in a very uncertain environment relative to the morbidity and volume of new business due to PPACA implementation. There is further uncertainty around some of the complex aspects of PPACA implementation, such as risk adjustment.

C. Actuarial Certification

I certify that this rate filing adheres to the laws of this state. I further certify that the assumptions used to develop rates are reasonable, that they have been set with an understanding of the business plan for this form series, and that they produce rates that are reasonable in relation to the benefits provided.

Stephen Arnhold, FSA, MAAA
Actuarial Director, Individual Medical Segment
May 14, 2013

Attachment 1

Administrative Expenses	**2012%**	**2013%**	**2014%**
Broker & Sales Commissions	6.8%	6.6%	4.4%
Quality Expenses	1.7%	2.2%	1.2%
Clinical & Network Operations	2.9%	2.8%	1.9%
IT Expenses	2.0%	2.7%	1.0%
Customer Service & Account Installation	2.1%	3.0%	1.6%
Corporate Administration	4.3%	4.2%	2.4%
Individual Administration	5.7%	6.3%	2.7%
Direct Response, Marketing, & Agency Management	2.2%	3.0%	1.6%
Total Admin	27.6%	30.8%	16.8%

Taxes			
State Premium Tax	0.3%	0.3%	0.3%
Health Insurer Annual Fee	0.0%	0.0%	1.4%
Exchange Fee	0.0%	0.0%	0.9%
Other Misc Taxes	0.1%	0.1%	0.1%
Income Taxes	-0.4%	-1.7%	2.5%
Total Taxes	-0.1%	-1.4%	5.1%
Post Tax Profit	-0.7%	-3.1%	3.1%

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

HumanaVitality, LLC

has received

ACCREDITATION WITH PERFORMANCE REPORTING

For service and program quality that meets NCQA's rigorous standards for comprehensively assessing wellness and health promotion programs and quality improvement.

CHAIR BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

September 11, 2012	***September 11, 2015***
DATE GRANTED	EXPIRATION DATE

September 12, 2012

Joe Woods MHA
Chief Executive Officer
HumanaVitality, LLC
550 West Adams St 5th Floor
Chicago, IL 60661

Dear Mr. Woods:

We are pleased to inform you that based on the information gathered during your recent WHP survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded HumanaVitality, LLC the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://iss.ncqa.org and looking under the section entitled Survey and Results.

Accreditation Status	Effective Date	Expiration Date
Accredited With Performance Reporting	September 11, 2012	September 11, 2015

The NCQA Health Plan Report Card has been updated to reflect this. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the 'Guidelines for Advertising NCQA WHP Survey Accreditation,' enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2009 *Standards and Guidelines for the Accreditation in Wellness & Health Promotion*. This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for WHP Accreditation Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

In order to maintain your accreditation status(es), HumanaVitality, LLC will need to participate in a survey approximately three months prior to the expiration date. Your next survey will be conducted in two stages using NCQA's Interactive Survey System (ISS) and standards in effect at the time of the survey. The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin eight weeks after your Survey Tool is submitted to NCQA.

We have tentatively reserved June 16, 2015, as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set August 3, 2015 for your onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please contact Cindy Francis, Program Manager, Accreditation, at (202) 955-5147 or e-mail francis@ncqa.org.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or e-mail customersupport@ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this accreditation survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Dayna McKnight, MBA, MS
Assistant Vice President, Accreditation

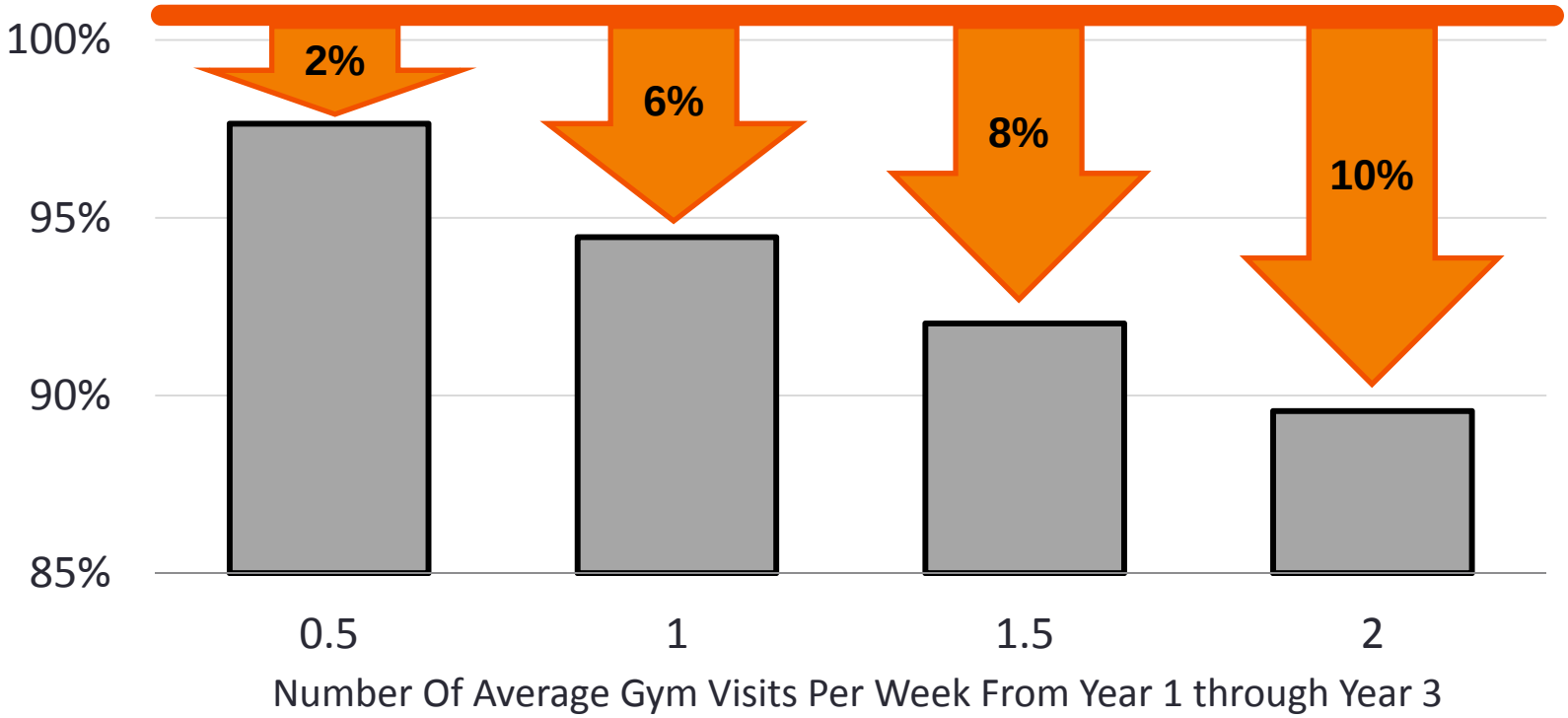
Enclosures

Increased Activity Decreases Odds Of Hospitalization

Relative Percent Hospitalized

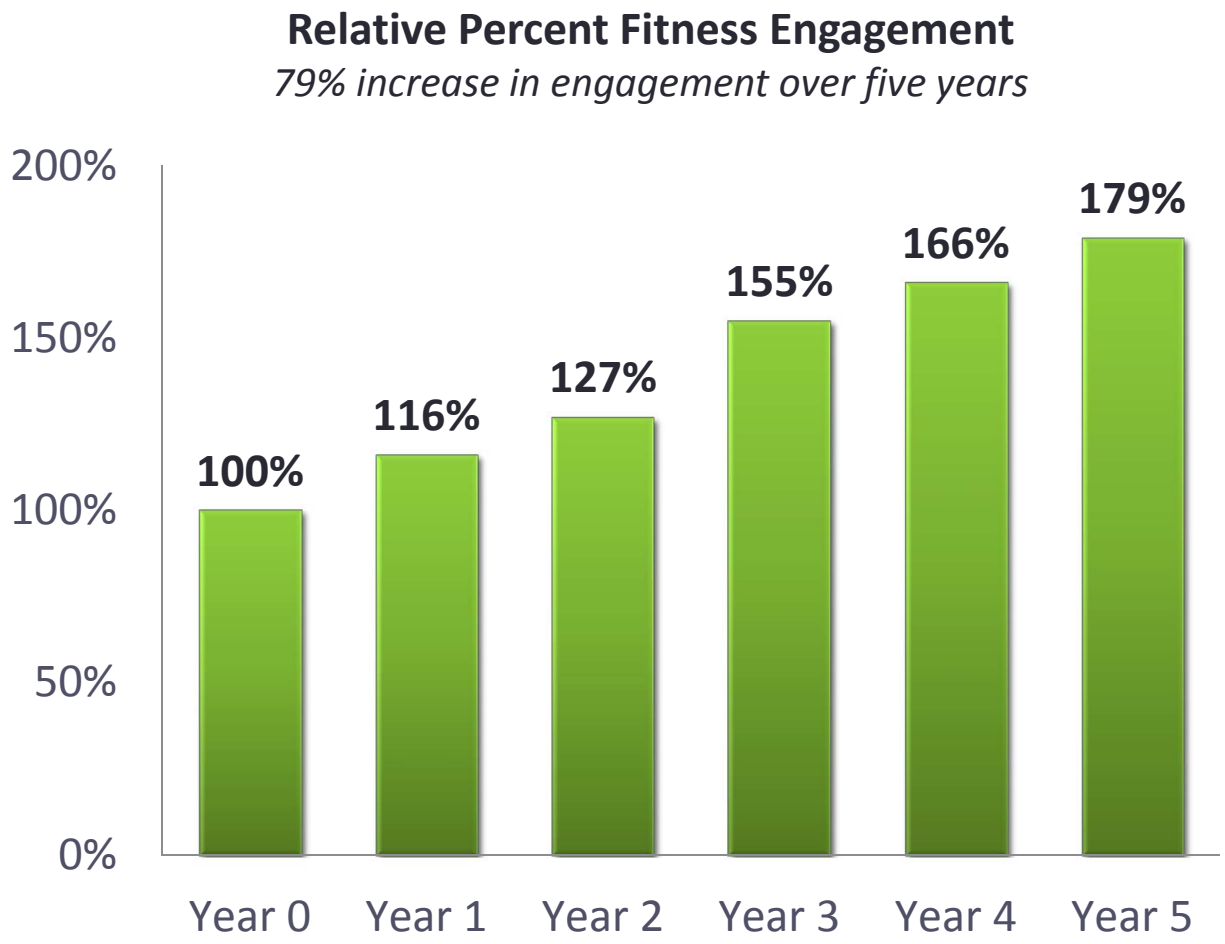
From Year 4 to 5 Compared To Inactive Members

10% decrease in odds of hospitalization for top engagement tier



Study of over 300,000 members: Deepak Patel, et al. (2011) Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study. American Journal of Health Promotion: May/June 2011, Vol. 25, No. 5, pp. 341-348.

Vitality Drives Fitness Engagement

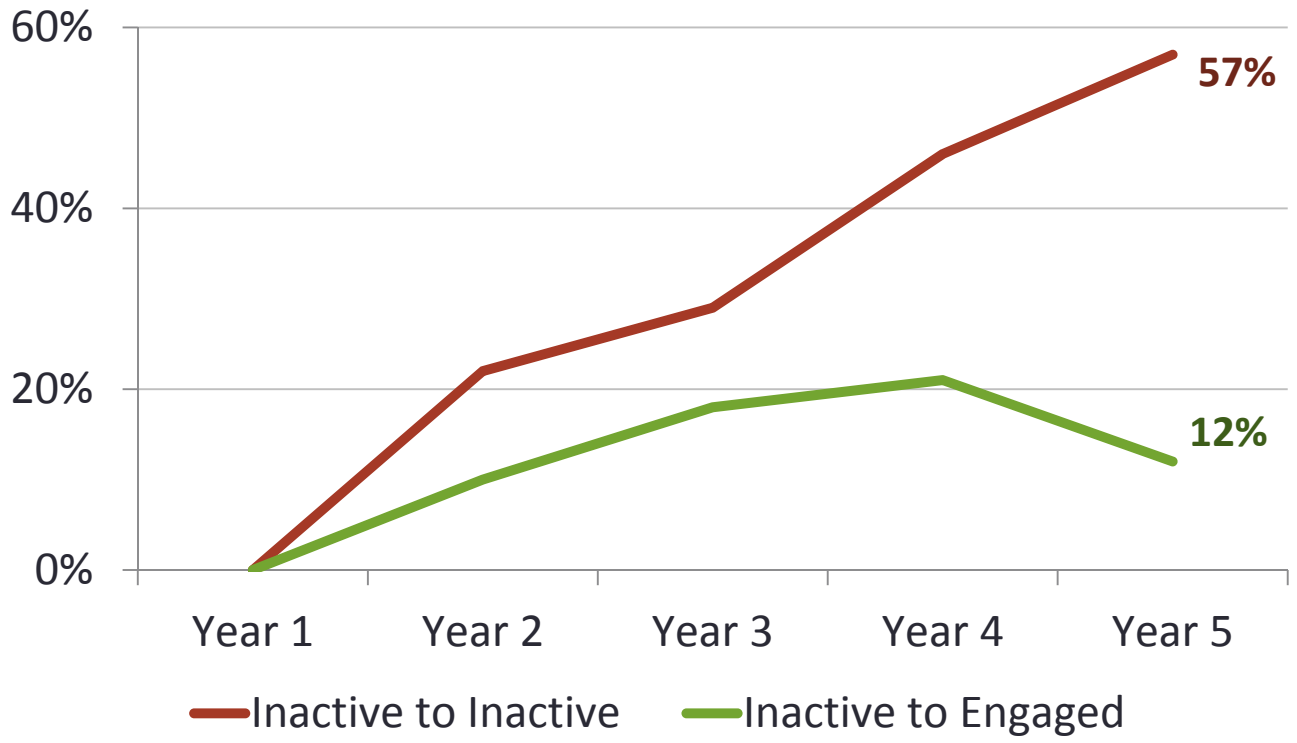


Deepak Patel, et al. (2011) Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study. American Journal of Health Promotion: May/June 2011, Vol. 25, No. 5, pp. 341-348.

Vitality Engagement Reduces Cost

Cumulative Trend for Initial Inactive Population That Became Engaged vs. Remained Inactive

45% cumulative trend reduction for members who became engaged



Source: Internal actuarial study.

Publication of Vitality longitudinal study

THE SCIENCE OF HEALTH PROMOTION

Financial Analysis

Participation in Fitness-Related Activities of an Incentive-Based Health Promotion Program and Hospital Costs: A Retrospective Longitudinal Study

Deepak Patel, MD, MSc; Estelle V. Lambert, PhD; Roseanne da Silva, BScHons, FIA; Mike Greyling, MSc; Tracy Kolbe-Alexander, BSc, PhD; Adam Noach, BSc; Jaco Conradie, BSc; Craig Nossel, MBChB, MBA; Jill Borresen, BSc, PhD; Thomas Gaziano, MD

Abstract

Purpose. *A retrospective, longitudinal study examined changes in participation in fitness-related activities and hospital claims over 5 years amongst members of an incentivized health promotion program offered by a private health insurer.*

Design. *A 3-year retrospective observational analysis measuring gym visits and participation in documented fitness-related activities, probability of hospital admission, and associated costs of admission.*

Setting. *A South African private health plan, Discovery Health and the Vitality health promotion program.*

Participants. *304,054 adult members of the Discovery medical plan, 192,467 of whom registered for the health promotion program and 111,587 members who were not on the program.*

Intervention. *Members were incentivized for fitness-related activities on the basis of the frequency of gym visits.*

Measures. *Changes in electronically documented gym visits and registered participation in fitness-related activities over 3 years and measures of association between changes in participation (years 1–3) and subsequent probability and costs of hospital admission (years 4–5). Hospital admissions and associated costs are based on claims extracted from the health insurer database.*

Analysis. *The probability of a claim modeled by using linear logistic regression and costs of claims examined by using general linear models. Propensity scores were estimated and included age, gender, registration for chronic disease benefits, plan type, and the presence of a claim during the transition period, and these were used as covariates in the final model.*

Results. *There was a significant decrease in the prevalence of inactive members (76% to 68%) over 5 years. Members who remained highly active (years 1–3) had a lower probability ($p < .05$) of hospital admission in years 4 to 5 (20.7%) compared with those who remained inactive (22.2%). The odds of admission were 13% lower for two additional gym visits per week (odds ratio, .87; 95% confidence interval [CI], .801–.949).*

Conclusion. *We observed an increase in fitness-related activities over time amongst members of this incentive-based health promotion program, which was associated with a lower probability of hospital admission and lower hospital costs in the subsequent 2 years. (Am J Health Promot 2011;25(5):341–348.)*

Key Words: Health Insurance, Wellness Program, Chronic Disease, Prevention Research.

Manuscript format: research; Research purpose: modeling/relationship testing, descriptive; Study design: retrospective longitudinal, analytic; Outcome measure: financial/economic, hospital costs; Setting: private national health insurer; Health focus: fitness/physical activity; Strategy: education, skill building/behavior change, incentives; Target population age: adults; Target population circumstances: health-insured population

Deepak Patel, MD, MSc is with UCT/MRC Research Unit for Exercise Science and Sports Medicine, University of Cape Town, Cape Town South Africa; and Discovery Health, Johannesburg, South Africa. Estelle V. Lambert, PhD; and Tracy Kolbe-Alexander, BSc, PhD, are with UCT/MRC Research Unit for Exercise Science and Sports Medicine, University of Cape Town, Cape Town, South Africa. Adam Noach, BSc; Jaco Conradie, BSc; Craig Nossel, MBChB, MBA; and Jill Borresen, BSc, PhD, are with Discovery Health, Johannesburg South Africa. Roseanne da Silva, BScHons, FIA, is with School of Statistics and Actuarial Science. Mike Greyling, MSc, is with School of Human and Community Development, University of Witwatersrand, Johannesburg, South Africa. Thomas Gaziano, MD, is with Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts.

Send reprint requests to Estelle V. Lambert, UCT/MRC Research Unit for Exercise Science and Sports Medicine, Department of Human Biology, Faculty of Health Sciences, University of Cape Town, PO Box 115, Newlands, Western Cape Town, 7725 South Africa; vicki.lambert@uct.ac.za.

This manuscript was received June 3, 2010; revisions were requested November 30, 2010, and January 18, 2011; the manuscript was accepted for publication January 20, 2011.

0890-1171/11/$5.00+ 0
DOI: 10.4278/ajhp.100603-QUAN-172

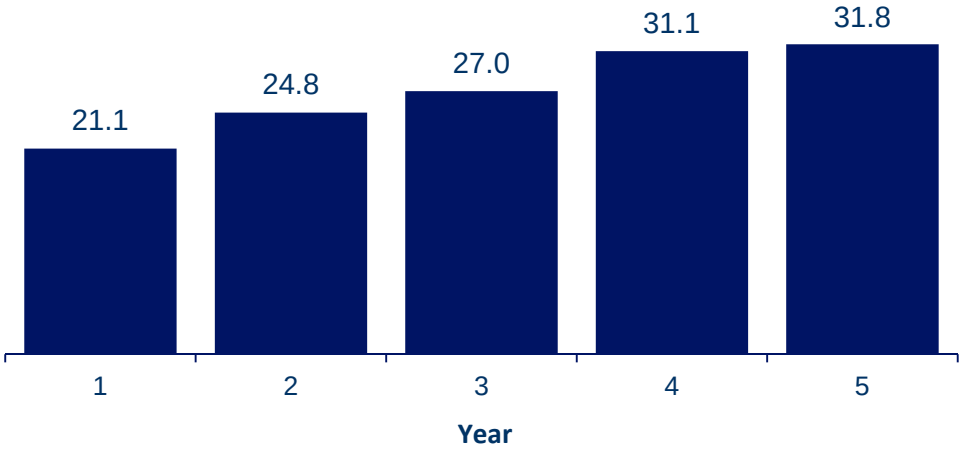
INTRODUCTION

Physical inactivity and sedentary living are major lifestyle factors that contribute to the growing burden of disease globally.[1] The effects of the increasing prevalence of inactivity are most evident in the increase in non-communicable chronic diseases of lifestyle, such as hypertension, type 2 diabetes, cancer, and coronary heart disease.[2]

There is compelling evidence for the beneficial effects of physical activity in the primary and secondary prevention of a large number of chronic diseases. Diseases such as type 2 diabetes,[3] hypertension[4,5] cardiovascular disease,[6] certain cancers,[4] mental illnesses,[7] and osteoporosis[8] are directly impacted by increasing physical activity. All-cause mortality, as well as deaths as a result of cardiovascular diseases and cancers, are significantly decreased with increased levels of physical activity.[9,10] Physical activity has also been shown to mitigate the effects of other risk factors. For example, overweight individuals who are fit have greater longevity than those normal-weight individuals who are unfit.[11,12] Likewise, it has been shown that physically active smokers have a lower risk of dying than non-active smokers.[13]

The enormous burden of diseases related to physical inactivity or sedentary living have significant direct and indirect economic consequences for the individual and for society.[14–16]

Increase in Fitness Engagement



Dose response of hospitalisation to gym visits

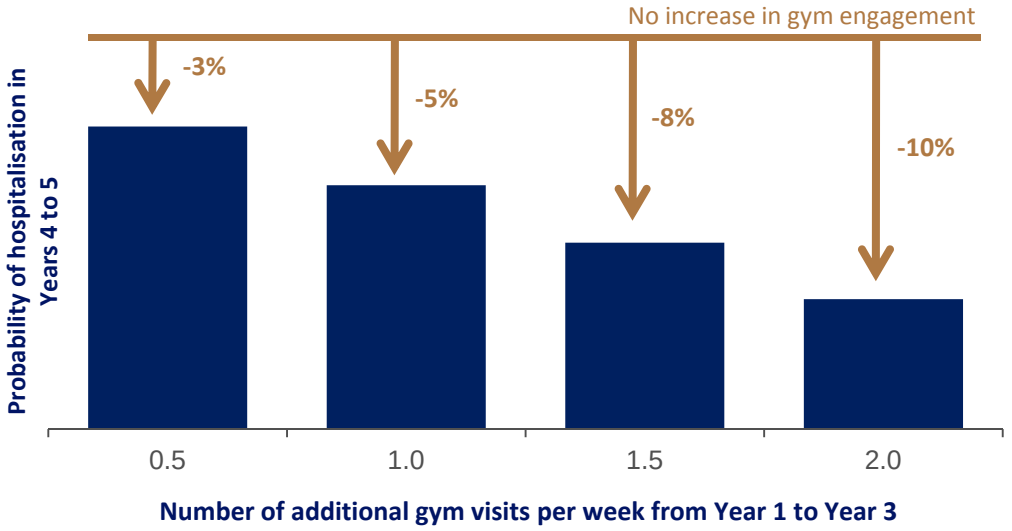


Exhibit C - Base Rate Development
Humana Health Plan

1)	Experience Period Allowed PMPM		$131.88	
2)	x Morbidity Change		2.821	
3)	x Medical Inflation & Trend[1]		1.064	
4)	x Increased Utilization[1]		1.128	
5)	x Change in Benefits		1.063	⎫
6)	x Change in Demographics		1.009	⎬ (5)x(6)x(7)=.814 ('Other' Column shown in URR)
7)	x Network Impacts		0.759	⎭
8)	= Total Impact		2.755	=(2)x(3)x(4)x(5)x(6)x(7)
9)	Projected Allowed PMPM	$	363.30	=(1)x(8)
10)	x Paid to Allowed Ratio		0.602	
11)	= Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM	$	218.71	=(9)x(10)
12)	- Projected Risk Adjustment PMPM		19.52	
13)	- Projected ACA Reinsurance Recoveries		23.05	
14)	= Projected Incurred Claims PMPM	$	176.14	=(11)-(12)-(13)
15)	+ Administrative Expense Load		39.47	
16)	+ Profit & Risk Load		7.28	
17)	+ Taxes & Fees		12.05	
18)	= Single Risk Pool Gross Premium Avg. Rate, PMPM	$	234.94	=(14)+(15)+(16)+(17)

[1] Medical Infaltion & Trend and Increased Utilization are 2 year figures.

Colorado
Humana Insurance Company & Humana Health Plan, Inc.
Seperation of Network Factors from Geographic Factors

To the extent allowed by applicable rating regulation, area rating for previously marketed products in the state of Colorado reflects historical claims experience to achieve the same target loss ratio for all geographic areas in the state. This means that the area factors on existing business under a certain legal entity currently include a component related to morbidity.

Beginning in 2014 such rating practice is no longer permitted on non-grandfathered products, and in order to comply with Federal market rating rules we have adjusted our area rating to strictly reflect only differences in underlying geographic charge levels and any anticipated network savings.

The final proposed geographic network factors, the development of which is illustrated below, will apply to new non-grandfathered business issued in 2014. They are produced by taking current area factors, adjusting them to reflect only underlying charge level, adjusting for anticipated relative network savings, and normalizing to an average overall factor of 1.0.

The applicability of these factors conforms to the standardized rating area definitions; however, within a particular area, one of several possible geographic network factors may apply, depending on the network of the plan selected. The difference between such factors reflects only the difference in expected network savings and efficiency. An example of this can be seen in rating area 2, where factors exist for both the HMOx and National POS networks, the difference of which reflects only the relative network savings and efficiency between the two networks.

					a				b		c	d	e = (a*b)		f = (a*c)		g = (a*d)		
						Raw Network Factor			Normalized Network Factor				Area Factor * Network Factor				Area * Network (Normalized)		
Rating	Reference Market	Current Area	Pure Unit	Area	Normalized Area	HIC	HHP		HIC	HHP			HIC	HHP			HIC	HHP	
Area	Name	Factor[1]	Cost Factor[1]	Factor[2]	Factor[3]	PPO	POS	HMOx	PPO	POS	HMOx		PPO	POS	HMOx		PPO	POS	HMOx
1	Boulder	1.1183	1.0916	1.1023	0.9773	1.0000	0.9800		1.0000	1.3757			0.9773	1.3445			0.9773	1.5280	
2	Colorado Springs	0.8435	0.9538	0.9097	0.8066	1.0000	0.9800	0.7195	1.0000	1.3757	1.0100		0.8066	1.1096	0.8146		0.8066	1.2611	0.9258
3	Denver	1.0442	1.0015	1.0186	0.9031	1.0000	0.9250	0.6644	1.0000	1.2985	0.9327		0.9031	1.1727	0.8423		0.9031	1.3328	0.9573
4	Fort Collins-Loveland	1.0103	1.1818	1.1132	0.9870	1.0000			1.0000				0.9870				0.9870		
5	Grand Junction	1.2301	1.1517	1.1831	1.0490	1.0000			1.0000				1.0490				1.0490		
6	Greeley	1.0103	1.1918	1.1192	0.9923	1.0000			1.0000				0.9923				0.9923		
7	Pueblo	1.3951	1.1818	1.2671	1.1235	1.0000			1.0000				1.1235				1.1235		
8	Other CO-East South	1.5464	1.0816	1.2675	1.1238	1.0000			1.0000				1.1238				1.1238		
9	Other CO-East North	1.4702	1.0816	1.2370	1.0968	1.0000			1.0000				1.0968				1.0968		
10	Other CO-West	1.6626	1.0816	1.3140	1.1651	1.0000			1.0000				1.1651				1.1651		
11	Other CO-Resort	1.4235	1.0816	1.2184	1.0802	1.0000			1.0000				1.0802				1.0802		
Average		1.0541	1.1770	1.1279	1.0000	1.0000	0.9410	0.6770	1.0000	1.3209	0.9503			1.1634	0.8360		1.0000	1.3223	0.9501
							0.7124			1.000				0.880				1.000	

[1] Reflect PPO Network filed under Humana Insurance Company

[2] A 60/40 blend of pure unit cost & current area is used here. The pure unit cost is not used because we believe provider utilization patterns not related to morbidity account for some of the variation in the current area factors

[3] Normalized to a 1.0 by using the PPO area distribution

Note: There was a minor error in the calculation of the PPO geographic network factor proposed above for the Boulder rating area. This error results in a factor that is approximately 5.7% lower than it otherwise should be, but we are deciding not to correct this factor at this time. As previously communicated, the PPO factor in Boulder rating area 1 (and similarly in rating areas 2 and 3) is only included for the purposes of supporting rate calculations for intrastate movers that wish to remain on their existing HumanaOne policy. Unless HumanaOne PPO policyholders, issued in 2014, move to rating area 1 during their 2014 plan year, this factor will not be used.

Network Discount Development

The 2014 Denver discount was calculated as described below:

	20.1%	savings in costs between HMO and NPOS in the Denver market
	0.799	savings converted to factor format (1 - 0.201 = .799)
x	0.992	multiplicative factor to recognize the removal of OON coverage
-	0.020	subtracted to account for the 2% savings expected from the HMO gatekeeper
-	0.054	subtracted to account for an expected savings from the prescription drug network and change to the formulary
=	0.719	combined network difference, which is a 28.1% network discount.
x	.925	relative to PPO (7.5% lower)
=	.6644	raw network factor

The 2014 Colorado Springs discount was calculated as described below:

	18.5%	savings in costs between HMO and NPOS in the Denver market
	0.815	savings converted to factor format (1 - 0.201 = .799)
x	0.992	multiplicative factor to recognize the removal of OON coverage
-	0.020	subtracted to account for the 2% savings expected from the HMO gatekeeper
-	0.054	subtracted to account for an expected savings from the prescription drug network and change to the formulary
=	0.734	combined network difference, which is a 26.6% network discount.
x	.980	relative to PPO (2% lower)
=	.7195	raw network factor

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/09/2013		Rate	2014 CO HHP Rate Manual	07/11/2013	CO HHP RATE MANUAL 01_01_2014.pdf (Superceded)
06/05/2013		Supporting Document	Actuarial Memorandum and Certifications	07/17/2013	COHMOActuarialMemorandumandExhibitsrevised2.pdf (Superceded)
06/05/2013		Supporting Document	Actuarial Memorandum	06/19/2013	2 - Actuarial Memorandum_HHP (2014.01.01).pdf (Superceded)
06/04/2013		Supporting Document	Exhibit B - Trend Exhibits	06/19/2013	3 - Trend Exhibits.pdf (Superceded)
06/03/2013		Supporting Document	Unified Rate Review Template	07/17/2013	H1_SBE_CO_HMO_unified_rate_review.xls (Superceded)
06/03/2013		Supporting Document	Rate Review Detail	06/19/2013	5- 2014 Rate-Rule Schedule & Rate Review Detail.pdf (Superceded)
05/15/2013		Rate	2014 CO HHP Rate Manual	07/09/2013	6 - CO HHP Rate Manual 2014_01_01.pdf (Superceded)
05/15/2013		Supporting Document	Actuarial Memorandum	06/05/2013	2 - Actuarial Memorandum CO HHP 2014_01_01.pdf (Superceded)
05/15/2013		Supporting Document	Exhibit A -CO HHP Past & Future Projected Experience	06/04/2013	3 - Exhibit A - CO HHP Past & Projected Future Experience.xlsx (Superceded)
05/15/2013		Supporting Document	Exhibit B - Trend Exhibits	06/04/2013	4 - Exhibit B - Trend Exhibits.xlsx (Superceded)

SERFF Tracking #: HUMA-129026181 **State Tracking #:** 278044 **Company Tracking #:**

State: Colorado **Filing Company:** Humana Health Plan Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005C Individual - Other
Product Name: HumanaOne Suite A HMOx; HumanaOne Suite C PPO
Project Name/Number: /

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/15/2013		Supporting Document	Rate Review Detail	06/03/2013	5 - 2014 Rate Review Detail Supporting Document.pdf (Superceded)
05/15/2013		Supporting Document	Rate Sample	05/30/2013	7 - CO HHP Rate Sample 2014_01_01.xlsx
05/13/2013		Supporting Document	Actuarial Memorandum and Certifications	06/05/2013	CO HMO Actuarial Memorandum and Exhibits_revised 2.pdf (Superceded)
05/13/2013		Supporting Document	Unified Rate Review Template	06/03/2013	UnifiedRateReviewSubmission-CO HMO.xml (Superceded)

Attachment H1_SBE_CO_HMO_unified_rate_review.xls is not a PDF document and cannot be reproduced here.

Attachment 3 - Exhibit A - CO HHP Past & Projected Future Experience.xlsx is not a PDF document and cannot be reproduced here.

Attachment 4 - Exhibit B - Trend Exhibits.xlsx is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission-CO HMO.xml is not a PDF document and cannot be reproduced here.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

CO-HHP
January 1, 2014
Rate Filing

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Average Premium

$234.95

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Plan Designs & Factors

Plan Marketing Name	HIOS Plan ID	Plan Suite	Plan Tier	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)	Off-Exchange (includes Ped. Dental)
Humana Connect Basic 6350/6350 Plan	74320CO0610001	Suite A	Catastrophic	$6,350	100%	$6,350	Integrated	0.7256	
Humana Connect Bronze 6300/6300 Plan	74320CO0610002	Suite A	Bronze	$6,300	100%	$6,300	Integrated	0.9132	
Humana Connect Silver 4600/6300 Plan	74320CO0610004	Suite A	Silver	$4,600	80%	$6,300	$1,500	1.0356	
Humana Connect Gold 2500/3500 Plan	74320CO0610006	Suite A	Gold	$2,500	80%	$3,500	$500	1.1812	
Humana Connect Platinum 1000/1500 Plan	74320CO0610007	Suite A	Platinum	$1,000	80%	$1,500	$500	1.3317	
Humana Connect Bronze 4850/6350 Plan	74320CO0610003	Suite A	Bronze	$4,850	80%	$6,350	$1,500	0.9843	
Humana Connect Silver 3650/3650 Plan	74320CO0610005	Suite A	Silver	$3,650	100%	$3,650	Integrated	1.0505	
Humana Connect Basic 6350/6350 Plan	74320CO0610008	Suite A	Catastrophic	$6,350	100%	$6,350	Integrated		0.7285
Humana Connect Bronze 6300/6300 Plan	74320CO0610009	Suite A	Bronze	$6,300	100%	$6,300	Integrated		0.9168
Humana Connect Silver 4600/6300 Plan	74320CO0610011	Suite A	Silver	$4,600	80%	$6,300	$1,500		1.0398
Humana Connect Gold 2500/3500 Plan	74320CO0610013	Suite A	Gold	$2,500	80%	$3,500	$500		1.1859
Humana Connect Platinum 1000/1500 Plan	74320CO0610014	Suite A	Platinum	$1,000	80%	$1,500	$500		1.3371
Humana Connect Bronze 4850/6350 Plan	74320CO0610010	Suite A	Bronze	$4,850	80%	$6,350	$1,500		0.9883
Humana Connect Silver 3650/3650 Plan	74320CO0610012	Suite A	Silver	$3,650	100%	$3,650	Integrated		1.0547
Humana Preferred Basic 6350/6350 Plan	74320CO0620001	Suite C - Rx4	Catastrophic	$6,350	100%	$6,350	Integrated		0.7603
Humana Preferred Bronze 4850/6350 Plan	74320CO0620003	Suite C - Rx4	Bronze	$4,850	80%	$6,350	$1,500		1.0269
Humana Preferred Silver 4250/6250 Plan	74320CO0620004	Suite C - Rx4	Silver	$4,250	80%	$6,250	$1,500		1.0739
Humana Preferred Bronze 6300/6300 Plan	74320CO0620002	Suite C - Rx4	Bronze	$6,300	100%	$6,300	Integrated		0.9128
Humana Preferred Silver 3650/3650 Plan	74320CO0620005	Suite C - Rx4	Silver	$3,650	100%	$3,650	Integrated		1.0554

Average Factor	1.0000

Cost Sharing Subsidized Plan Designs

Plan Name	HIOS Plan ID	Plan Suite	FPL	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)
Humana Connect Silver 4600/6300 Plan	74320CO0610004-03	Suite A	250+	$4,600	80%	$6,300	$1,500	1.0356
	74320CO0610004-04	Suite A	200 - 250	$3,250	80%	$4,750	$1,000	1.0356
	74320CO0610004-05	Suite A	150 - 200	$900	80%	$1,450	$500	1.0356
	74320CO0610004-06	Suite A	100 - 150	$500	80%	$750	$250	1.0356
Humana Connect Silver 3650/3650 Plan	74320CO0610005-03	Suite A	250+	$3,650	100%	$3,650	Integrated	1.0505
	74320CO0610005-04	Suite A	200 - 250	$2,920	100%	$2,920	Integrated	1.0505
	74320CO0610005-05	Suite A	150 - 200	$1,100	100%	$1,100	Integrated	1.0505
	74320CO0610005-06	Suite A	100 - 150	$475	100%	$475	Integrated	1.0505

In addition to the Silver plan variations shown above, all on-exchange metal tier plans will also have a 100% Cost Sharing Plan Design for American Indians/Alaska Natives, and for pricing purposes, will use the plan factors shown in the top table.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Age Factors

Age of Member	Factor	Demonstration of Compliance Factor compared to age 21
Fourth+ Dependents	0.0000	0.000
0-20	0.5372	0.635
21	0.8461	1.000
22	0.8461	1.000
23	0.8461	1.000
24	0.8461	1.000
25	0.8494	1.004
26	0.8664	1.024
27	0.8867	1.048
28	0.9197	1.087
29	0.9467	1.119
30	0.9603	1.135
31	0.9806	1.159
32	1.0009	1.183
33	1.0136	1.198
34	1.0271	1.214
35	1.0339	1.222
36	1.0406	1.230
37	1.0474	1.238
38	1.0542	1.246
39	1.0677	1.262
40	1.0813	1.278
41	1.1016	1.302
42	1.1210	1.325
43	1.1481	1.357
44	1.1819	1.397
45	1.2217	1.444
46	1.2691	1.500
47	1.3224	1.563
48	1.3833	1.635
49	1.4434	1.706
50	1.5111	1.786
51	1.5779	1.865
52	1.6515	1.952
53	1.7260	2.040
54	1.8063	2.135
55	1.8867	2.230
56	1.9738	2.333
57	2.0618	2.437
58	2.1558	2.548
59	2.2023	2.603
60	2.2962	2.714
61	2.3774	2.810
62	2.4307	2.873
63	2.4976	2.952
64+	2.5382	3.000

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
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Tobacco Use Factors

The following factors will be applied based on the member's tobacco usage, as determined by the tobacco usage guidelines.

Age of Member	Non-Tobacco User	Tobacco User	Demonstration of Compliance Factor compared to Non-Tobacco User
0-20	0.9941	0.9941	1.000
21	0.9941	1.0935	1.100
22	0.9941	1.0935	1.100
23	0.9941	1.0935	1.100
24	0.9941	1.0935	1.100
25	0.9941	1.0935	1.100
26	0.9941	1.0935	1.100
27	0.9941	1.0935	1.100
28	0.9941	1.0935	1.100
29	0.9941	1.0935	1.100
30	0.9941	1.0935	1.100
31	0.9941	1.0935	1.100
32	0.9941	1.0935	1.100
33	0.9941	1.0935	1.100
34	0.9941	1.0935	1.100
35	0.9941	1.0935	1.100
36	0.9941	1.0935	1.100
37	0.9941	1.0935	1.100
38	0.9941	1.0935	1.100
39	0.9941	1.0935	1.100
40	0.9941	1.0935	1.100
41	0.9941	1.0935	1.100
42	0.9941	1.0935	1.100
43	0.9941	1.0935	1.100
44	0.9941	1.0935	1.100
45	0.9941	1.0935	1.100
46	0.9941	1.0935	1.100
47	0.9941	1.0935	1.100
48	0.9941	1.0935	1.100
49	0.9941	1.0935	1.100
50	0.9941	1.0935	1.100
51	0.9941	1.0935	1.100
52	0.9941	1.0935	1.100
53	0.9941	1.0935	1.100
54	0.9941	1.0935	1.100
55	0.9941	1.0935	1.100
56	0.9941	1.0935	1.100
57	0.9941	1.0935	1.100
58	0.9941	1.0935	1.100
59	0.9941	1.0935	1.100
60	0.9941	1.0935	1.100
61	0.9941	1.0935	1.100
62	0.9941	1.0935	1.100
63	0.9941	1.0935	1.100
64+	0.9941	1.0935	1.100

Average Factor	1.0000

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Geographic Network Factors

The following factors will be applied according to the policyholder's place of residence.

		Network	
Rating Area	Reference Market Name	HMOx	POS
1	Boulder	-	1.5280
2	Colorado Springs	0.9259	1.2611
3	Denver	0.9573	1.3327
4	-	-	-
5	-	-	-
6	-	-	-
7	-	-	-
8	-	-	-
9	-	-	-
10	-	-	-
11	-	-	-

Average Factor	1.0000

Humana Health Plan, Inc.
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Plan Distribution

	New Business				Renewal Only	
	On-Exchange		Off-Exchange		Off-Exchange	
	Network		Network		Network	
Plan Suite	HMOx	POS	HMOx	POS	HMOx	POS
Suite A Suite C - Rx4 Refresh PHP	X		X	X		

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Definition of Service Areas

Service areas are defined by groups of counties.
For reference only. For complete plan availability, see the Service Area template.

		Network	
Rating Area	Reference Market Name	HMOx	POS
1	Boulder	n/a	Boulder
2	Colorado Springs	El Paso, Teller	El Paso, Teller
3	Denver	Adams, Arapahoe, Broomfield, Denver, Douglas, Jefferson	Adams, Arapahoe, Broomfield, Denver, Douglas, Elbert, Jefferson
4	-	n/a	n/a
5	-	n/a	n/a
6	-	n/a	n/a
7	-	n/a	n/a
8	-	n/a	n/a
9	-	n/a	n/a
10	-	n/a	n/a
11	-	n/a	n/a

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Modal Factors

The following factors will be applied according to the payment mode selected.
These factors will be applied at the end of the rate calculation.

Payment Frequency	Factor
Monthly	1.0000
Quarterly	3.0000
Semi-Annual	6.0000

An administrative fee of $5 will be charged for each paper bill generated and each recurring credit card transaction. The fee is waived for electronic funds transmission (EFT). A $25 fee is charged for checks returned with, or Electronic Fund Transactions resulting in, insufficient funds. A $25 fee is charged for late payment and a $25 fee is charged to reinstate a lapsed policy.

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Algorithm Details

Step through this algorithm for each member.

	Average Premium
x	Plan Factor
x	Age Factor
x	Tobacco Use Factor
x	Geographic Network Factor
=	Subtotal *(rounded to nearest penny)*
x	Modal Factor
=	Rate

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Sample Rate Calculation

Plan: Humana Connect Bronze 6300/6300 Plan
Availability: On-Exchange (no Ped. Dental)
Tobacco Use: Non-Tobacco User
Rating Area: 3
Reference Market: Denver
Network: HMOx
Payment Mode: Monthly

		Mbr #1	Mbr #2	Mbr #3	Mbr #4	Mbr #5	Mbr #6	
	Age:	33	32	7	5	3	1	
	Average Premium	$234.95	$234.95	$234.95	$234.95	$234.95	$234.95	
x	Plan Factor	0.9132	0.9132	0.9132	0.9132	0.9132	0.9132	
x	Age Factor	1.0136	1.0009	0.5372	0.5372	0.5372	0.0000	
x	Tobacco Use Factor	0.9941	0.9941	0.9941	0.9941	0.9941	0.9941	
x	Geographic Network Factor	0.9573	0.9573	0.9573	0.9573	0.9573	0.9573	
=	Subtotal *(rounded to nearest penny)*	$206.96	$204.37	$109.69	$109.69	$109.69	$0.00	
x	Modal Factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
=	Rate	$206.96	$204.37	$109.69	$109.69	$109.69	$0.00	$740.40

Humana Health Plan, Inc.
Colorado
HIOS Identification: 74320

This filing is for the individual market, with an effective date of 01/01/2014.

Contact Information:
Primary Contact: Emma Erickson
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Purpose:

The purpose of this actuarial memorandum is to provide supporting justification to the Unified Rate Review template with the goal of demonstrating compliance with the market rating rules, as well as reasonableness of any proposed rates.

In addition, this actuarial memorandum provides required actuarial certifications related to:

- the methodology used to calculate the AV Metal Value for each plan
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based
- the index rate is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates

This filing should be used for no other purposes.

This memorandum was prepared by a qualified actuary, and is intended to be reviewed by a qualified actuary.

Reasons for Rate Increases

This actuarial memorandum accommodates our rates developed for new products.

The following paragraphs detail the components of the change in index rate used in development for our new 2014 products. Following a summary of the cumulative impacts at the beginning of this memo, we will walk through each item, how it impacts 2014 index rates, and the quantification.

Rate Increases Driven by Changes in Allowed Claims

A. Morbidity……	182.1%
B. Medical Inflation & Trend……	6.4%
C. Increased Utilization……	13.2%
D. Change in Benefits……	6.3%
E. Change in Demographics……	0.9%
F. Network Impacts……	-24.1%
Total……	176.6%

Other Rate Increase Drivers

G. New Taxes & Fees……	2.3%
H. Reinsurance Program……	-9.8%
I. Risk Adjustment……	-8.3%
Total……	-15.4%
Grand Total……	134.0%

A. Single risk pool experience which is more adverse than that assumed in the current rates & morbidity:

This adjustment is intended to capture the change in underlying morbidity for the risk pool in 2014 compared to the current risk pool. Due to the removal of pre-existing condition limitations combined with 2014 rules disallowing underwriting rate adjustment or exclusionary riders, it is anticipated that the average morbidity for policies issued in 2014 will be much greater than the average morbidity in the individual market today.

Morbidity levels are expected to be similar to those of small group given that the underwriting will be similar between the segments in 2014. It is reasonable to assume that individual morbidity will be higher since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas, in the small group market, it is a by-product of being employed by the organization. Similarly, the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market. For these reasons, the starting point for developing the 2014 guaranteed issue impact is gauging the relative morbidity between the individual and small group markets today. External consultants were also worked with to estimate the impact of the new single risk pool experience.

Increased utilization due to the impact of member behavioral changes when on a plan with richer benefits must be accounted for. This excludes the impact of health status. Further detail on the impact of increased utilization by plan and level of cost sharing subsidization is detailed later in the actuarial memorandum.

The impact of morbidity in Colorado for Humana Health Plan, Inc. is 182.1%.

B. Medical inflation & medical cost claims trend:

Rate increases required to account for increases in medical claim costs were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.

The impact of medical inflation and medical cost claims trend from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 6.4%, or 3.1% annualized.

C. Increased Utilization

Rate increases required to account for increases in utilization were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.

The impact of increased utilization from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 13.2%, or 6.4% annualized.

D. Change in Benefits

All non-grandfathered plans must cover the essential health benefits package in 2014. The specifics of the essential health benefits are contained within the benchmark plan selected in each state.

There are two high level categories of benefits that require rate increases to account for in the individual market: behavioral services and other state-specific services.

Current plans do cover behavioral services but also impose visit limits as well as lower coinsurance rates and separate deductibles. The modification of cost sharing requires additional rate to cover the expected increase cost of services. State specific requirements embedded in the benchmark plan must also be provided and rates adjusted in accordance.

Please note, maternity coverage is already mandated in Colorado. An adjustment was made to account for the level of maternity claims expected in 2014 compared to the low level of maternity claims in the base experience period.

The impact of change in benefits in Colorado for Humana Health Plan, Inc. is 6.3%.

E. Change in Demographics

The change in demographics is meant to represent the shift in area mix of business distribution between 2012 and the new 2014 environment.

With the anticipated growth for 2014 and strategic selection of where products will be sold both on and off-exchange, there is an expected impact to the distribution of business by area. Since claim costs are known to vary by area, it is important to reflect this change.

The impact of change in demographics in Colorado for Humana Health Plan, Inc. is 0.9%.

F. Network Impacts

New products in 2014 will be tied to new networks in many markets, particularly on exchange where network selection was made in order to achieve lower claim costs. There are four components to the network savings: improved network discounts, removal of out-of-network coverage, new pharmacy network and formulary, and care coordinator savings.

The impact of these network impacts in Colorado for Humana Health Plan, Inc. is -24.1%.

G. New Taxes & Fees Imposed on the Insurer

There are two additional taxes and fees for 2014 that must be considered in the pricing:

1) 1.4% additional federal tax

2) Exchange user fee of 0.9% of premium

The additional federal tax is the $8 billion tax assessed on the insurance industry for 2014. Humana's estimated liability based on net premium share of the market is $505M. Price adjustments are required to reflect the liability compared to the estimated 2014 company premium revenue. This is not tax-deductible, the appropriate increased federal income tax liability is captured in the income tax line in the expense exhibit discussed later in the actuarial memorandum.

The exchange user fee applies only to on-exchange business but must be spread across all business.

The impact of new taxes and fees imposed on the insurer in Colorado for Humana Health Plan, Inc. is 2.3%.

H. Changes in payments from and contributions to the Federal Transitional Reinsurance Program

Rate adjustment to account for projected reinsurance recoveries net of reinsurance premium were also included in the rate development. Details of how projections were established and the corresponding magnitude are discussed at greater length later in the memorandum.

The impact driven by the Federal Transitional Reinsurance Program in Colorado for Humana Health Plan, Inc. is -9.8%.

I. Risk Adjustment

Expected Risk Adjustment Transfer payments must be incorporated in rate development. Transfer payments received or paid impact plan liabilities and therefore rates must be adjusted accordingly. Further detail on the development of this adjustment is discussed later in the memorandum.

The impact of risk adjustment in Colorado for Humana Health Plan, Inc. is -8.3%.

Additional Commentary on Reasons for Rate Increases

It should be noted that given the timeline of release of regulations, template requirements, and submission deadlines, pricing methodologies different from those prescribed by the Universal Rate Review Template were employed to develop 2014 pricing.

Experience Period Premium and Claims

Paid Through Date:	February 28, 2013	
Premiums net of MLR rebate:	$	12,811,963
MLR Rebates:	$	15,951
Estimated Rebates to be included:	$	-

Methodology for estimated Rebates: Rebates are the year-end accrual for 2012. The estimate was based on actual claims through the end of September 2012, with data projected through the end of the year. Since we have no state and legal entities that are fully credible in 2012 on their own, the 2012 rebates are based on two years worth of data. The 2011 data utilizes the submission used to generate rebates for the 2011 experience. Expense adjustments allowed under the rebate rules are estimated based on expense experience and future expectations.

	Allowed Claims	Incurred Claims
Claims that were processed through the issuer's claim system	$ 10,787,110	$ 6,235,799
Claims that were processed outside the issuer's claim system	$ 964,462	$ 194,443
Claims incurred but not paid as of paid through date	$ 380,980	$ 208,465

The processed claims are claims incurred in 2012 paid through February 2013. The allowed amount comes directly from the claims system after eligibility and network discounts are applied.

To estimate incurred claims, reserve cells are categorized at the product and type of service detail and development methods with various averaging techniques are utilized, most commonly a six-month average excluding the high and low factors. Smoothing techniques are employed, including workday and seasonality adjustments. Changes in claim volume are included in these estimates by adjusting for pended claims.

For each month of incurral, the incurred but not reported amount equals the incurred claims estimate minus claims paid to date.

Follow-up studies, including monthly historical reserve restatement analyses, are regularly performed to test the accuracy of the reserving methodology and suggest possible improvements.

Allowed but not reported estimates are developed utilizing the combination of the incurred but not reported estimate and the incurred to allowed ratio of historical claims.

Benefit Categories

The Benefit Categories are defined as follows:

Inpatient Hospital: Includes non-capitated services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility. The Outpatient Hospital benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Outpatient Surgery and Emergency Room, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Outpatient Therapy or MRI, services are used for the measurement units.

Professional: Includes non-capitated primary care, specialist, therapy, laboratory, radiology, and other professional services not billed by the facility. The Professional benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Primary Care or Specialist Office visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Therapy or MRI, services are used for the measurement units.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. The Other Medical benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Home Health visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as DME, services are used for the measurement units.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. Costs are net of rebates received from drug manufacturers, as required.

Projection Factors

182.1% **Changes in the Morbidity of the Population Insured [A]**

This adjustment is intended to capture the change in underlying morbidity for the risk pool in 2014 compared to the current risk pool. To calculate the change in morbidity, both internal pricing analysis and consultant reviews were utilized. Internal modeling considered the relative morbidity of the current uninsured market, combined with the relative morbidity of the membership on employer plans and the migration between segments. It is additionally anticipated that the resulting morbidity for the new 2014 business that will be issued in the individual market will be slightly higher than the morbidity levels of the small group market in 2014. Intuitively, morbidity levels similar to those of small group are expected given that the underwriting will be similar between the segments in 2014. The fact that individual morbidity will be higher is also a reasonable assumption since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas in the small group market, it is a by-product of being employed by the organization. Similarly the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market.

This data was adjusted to account for relative morbidity differences between the two segments, geographic mix differences, anticipated difference between the coverage of benefits, level of large claims, and new presence of richer benefits inducing additional demand. Analysis included consideration for the amount of new membership for the issuer at a higher morbidity level compared to the amount of existing membership at a lower morbidity level and change in renewal patterns. Internal modeling utilized consultant feedback for both growth factor estimates and also as a reasonability check.

The impact of morbidity, part of [A] above, is 74.3%.

The policy reserve adjustment is a portion of the MLR calculation that is unique to individual medical for policies effective in 2013 and earlier.

It is an MLR leveling mechanism that is needed to account for the fact that early duration loss ratios are significantly lower than later duration loss ratios.

The factors used for this adjustment were developed by comparing the claims over premium to claims plus change in policy reserves over premium in the experience period.

The change in reserves is the amount intended to levelize the claims plus change in policy reserves over premium ratio over the course of the policy life and therefore is used as a measure for how much the claims need to be modified by to get to an average lifetime level of morbidity. The source of the policy reserve data is the change in policy reserve information for the single risk pool.

The impact of the policy reserve adjustment, part of [A] above, is 53.1%.

The plan mix adjustment represents the impact to the allowed claims due to the anticipated change in benefit selection patterns between the base 2012 experience period and projected 2014 rating period.

This state's 2012 experience base is comprised of a relatively leaner benefit plan mix than we expect to have in 2014, due to the more select, healthier composition of the population underlying it.

In order to account for the absence of such positive selection in a more standard 2014 population, the allowed claims have increased.

This impact was quantified by comparing the anticipated 2014 benefit plan distribution against that which underlies the state's specific 2012 experience base.

Each was weighted by 2012 premiums for each benefit plan, normalized for the difference in paid to allowed ratio.

The impact of the plan mix adjustment, part of [A] above, is 5.8%.

6.3% **Changes in Benefits [D]**

As outlined in the "Reasons for Rate Increases" portion of the memorandum, this reflects the changes in benefits available to membership including adding maternity benefits, modification for behavioral health services cost-sharing and state mandated benefits as function of the benchmark plan. The data used to derive the estimated impact of adding maternity coverage was based on Humana Small Group data since many Humana individual plans currently do not include maternity coverage in the state. The methodology employed was comparing the level of maternity claims compared to the total claims. This was adjusted to account for anticipated increase in maternity incident rates given the mix of business differences between small group and individual by federal poverty levels. The estimated impact of the contraceptive coverage under the Women's Preventive Care legislation was additionally taken into account as an offset to the higher incidence rates.

The data used to derive the estimated impact of changes in member cost-sharing levels for behavioral health services was based on small group data as well. This exercise started with an analysis of behavioral health claims compared to total and compared the marginal benefit ratio of the new and current plans that will result due to the Federal Mental Health Parity requirements. State specific mandated benefits based on the benchmark plans were determined individually using similar methodologies.

0.9% **Changes in Demographics [E]**

This factor represents the impact to the allowed claims with respect to the change in demographics between the base 2012 experience period and the expected demographic mix in 2014.

The process used to derive the change in area began with the distribution of business in 2012 and expected in 2014 by state and legal entity. Each of these was weighted with average premium per member per month in each state and legal entity market. The change in the overall state and legal entity's weighted premium per member per month dictated the expected impact due to the shift to the new 2014 geographic distribution. Age and gender were held constant in this exercise.

-24.1% **Other Adjustments - Network Impact [F]**

This factor represents the impact to the allowed claims with the presence of new networks on new products in 2014 in many markets. Data used to evaluate this claim impact is based on Humana claims at a corporate level as well as the individual market. To generate the estimated impact, network savings were generated relative to the base network underlying the current products.

Additionally for new HMO networks, the reduction in claims achieved by removing out-of-network coverage was determined by comparing the average cost per service in-network compared to the cost per service out-of-network. Also for new HMO networks an adjustment was made to account for the presence of a new pharmacy network. Finally network claim impacts account for the estimated savings for care coordinators as part of a HMO network to manage referrals for specialty care and inpatient stays.

20.4% **Trend Factors: Cost & Utilization [B & C]**

The cost trend captures pure unit cost changes from midpoint 2012 to midpoint 2014, calculated using the same basket of services each period, due to price/contract negotiations and provider distribution changes. Inpatient Hospital, Outpatient Hospital, Professional, Capitation and Other Medical cost trends are developed based on historical area specific cost trends from Humana's Individual Commercial block of business data. Future cost trends are developed based on expected changes in Humana's Commercial contracts.
Pharmacy cost trends are developed based on historical brand, generic, and specialty drug trends from Humana's Commercial data. Future cost trends are developed based on expected changes in these pharmacy contracts.

These contractual impacts will be applicable to all members regardless of risk class.

Utilization trend:
Using Humana's Trend Quantification and Projection model, a baseline utilization trend is developed using Humana's Individual Commercial block of business historical medical claims data from 2008 - 2012. The historical baseline utilization trend is developed by removing all known impacts to utilization net trend such as demographics, geography, duration, customer changes, benefit changes, new health technologies, utilization management initiatives, and changes in pertinent days. An economic regression model, based on consumer sentiment, personal disposable income, hospital construction, and high-tech medical equipment spend, is then fit to this historical baseline utilization data to project the future block of business baseline utilization trend for 2013 and 2014.
A midpoint to midpoint methodology is applied to determine the applicable baseline utilization trend, which incorporates 2012q3 and 2012q4 actual results at the state and legal entity level with the block of business baseline utilization trend for 2013 and 2014. This results in baseline utilization trends that vary at the state and legal entity level.

Other components are added to the baseline utilization trend to develop the total utilization trend provided. These include the following:
• Pertinent days – Captures changes in the calendar, recognizing that health care utilization varies by day of the week and reporting periods contain varying weekday mix and count. This impact is developed through the use of an external consultant's model which is uploaded with Humana's Commercial claims data.
• New Health Technologies – Captures the impact of new health technologies and procedures. An external consulting firm researches new technologies and develops per member per month impacts. These impacts are customized to Humana's Commercial business based on membership and coverage policy.
• Management Initiatives – Captures savings for Humana initiatives designed to bend trend by managing utilization, such as case management, disease management, and nurse programs. These initiatives are evaluated by an internal actuarial organization tasked with evaluating the effectiveness of the initiatives. Evaluations are done through a collaborative effort involving clinical and other operational areas. Projected savings are calculated by determining prospective changes to impacted metric values, which are determined by analyzing historical metric values as well as through discussions with clinical and operational areas. Savings are reviewed with leadership to ensure appropriateness of assumptions.
This describes the development of the core utilization trend. All impacts from healthcare reform have been removed and are included in the "Population Risk/Morbidity" and "Other" adjustments from Worksheet 1 to prevent double counting of any impacts.

Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used, Adjustments Made to the Data, Inclusion of Capitation Payments

To credibility adjust this block of business, a credibility manual consisting of slight modifications to 2014 market projections was utilized.

Source data utilized for the credbility manual calculation includes Colorado Humana Health Plan, Inc. utilization per 1000 that mirrors the 2014 projected experience, adjusting to reflect the overall credibility of the block of business that we apply in pricing to ensure adequacy of rates.

The average cost per service is driven by the Colorado Humana Health Plan, Inc. 2014 projected experience in order to maintain representation of the provider contracts and distribution mix represented in the allowed claim derivation, also adjusted to reflect the credibility of the block of business to ensure pricing adequacy.

We do not expect to have services in the projection period provided under a capitation arrangement.

Credibility of Experience

The state of Colorado has mandated a level of 24,000 member months for full credibility. Per that mandate, our credibility weight methodology has been adjusted to reflect utilizing the following equation: square root(member months in experience period/24000).

To account for the presence of Colorado Humana Health Plan, Inc. experience in the credibility manual, the credibility level afore mentioned has been reduced by a factor of the expected 2014 membership relative to nationwide.

Paid to Allowed Ratio

The anticipated paid to allowed average factor over the projection period was developed by separately considering the anticipated paid to allowed factors by individual plan tier.

Once calculated, projected member month weights for each plan tier (consistent with those provided in Worksheet 2) were applied to these paid to allowed factors to produce an overall anticipated paid to allowed average factor of 60.2%.

The individual plan tier paid to allowed factors were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. These values were developed in accordance with generally accepted actuarial principles and methodologies.

Risk Adjustment and Reinsurance

Projected Risk Adjustment PMPM

The 2014 Risk Adjustment Transfer Payments are determined via a model that projects all large issuers in the state. This is necessary to estimate the state average premium and other normalization factors required by the HHS transfer formula. The model uses the formulas/factors prescribed by HHS to determine the transfer payments, state average premium, GCF (Geographic Cost Factor), IDF (Induced Demand Factor), ARF (Age Rating Factor), and AV (Actuarial Value). Furthermore, the model utilizes separate risk pools for Catastrophic and Metal Plans as described in the regulations. Since limited information is available for other issuers, most assumptions were set universally across issuers.

Membership mix by plan, as shown in column A of Exhibit 1, was determined by simulating member plan choices in 2014. The simulation uses Humana Small Group membership, because it should closely approximate the risk profile of new 2014 enrollees. A member's utility for each of the plans was estimated based on the post subsidy premium and the member cost sharing (after subsidies) given their health status. The member selects the plan with highest utility (subject to Catastrophic plan eligibility rules). This approach captures the impact of adverse selection by plan. In addition, the simulation produces a Plan Liability Risk Score (column C) for each member based on the HHS Commercial Risk Adjustment Model. This risk score is used in the calculation of risk transfer payments.

Members issued prior to 2014 also have risk scores calculated and are mapped to an ACA compliant plan that is similar to their current plan. All issuers are assumed to have the same plan mix. The primary driver of issuer specific risk scores is the projected mix of underwritten and non-underwritten membership. Previously underwritten members will be healthier than the cohort of business enrolled under guaranteed issue and will push risk scores lower.

Humana expects above average membership growth in 2014 due to below average anticipated unit costs resulting from significant unit cost improvements. This will translate into a smaller proportion of underwritten business and higher risk scores.

The percent of underwritten membership (column B) is determined based on a sales projection model. The model assumes initial membership for each issuer based on the 2011 SHCE. New enrollees are attributed to each issuer based on assumed price competitiveness in each market and an Individual Market growth assumption.

The Colorado Individual market is assumed to grow 41.2% in 2014. For Humana Health Plan, Inc., these sales assumptions result in below average portion of underwritten membership and therefore above average Plan Liability Risk Score.

In accordance with HHS regulations, state average premium is calculated as a membership-weighted average of issuer premiums. Premium (column H) for each issuer is calculated to be the projected Total Liability PMPM (column G) divided by the target loss ratio. Total Liability is paid claims including induced utilization (column D) less projected risk adjustment transfers (column F) and less projected reinsurance recoveries net of contributions (column E). It is necessary to include reinsurance recoveries in the calculation because this will result in substantially lower premiums in the Individual market. The approach described above is similar to the method used in the September 2011 CCIIO whitepaper on risk adjustment.

Based on the above assumptions, Risk Adjustment Transfer Payments are calculated for each risk pool using the HHS transfer formula. As a result, Humana Health Plan, Inc. expects a $0.10 PMPM average Risk Adjustment Transfer Payment from HHS on Catastrophic plans. On metal plans Humana Health Plan, Inc. expects a $21.22 PMPM average Risk Adjustment Transfer Payment from HHS.

These result in -0.1% and -8.8% adjustments to premiums for Catastrophic and Metal plans, respectively. In compliance with rating rules, all Metal plan premiums are adjusted uniformly by -8.8% as demonstrated in column J of Exhibit 1.

Projected Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance recoveries were calculated using claims data from the simulated populations mentioned above. Humana Small Group membership was used to represent the risk of new enrollees in 2014. This is expected to be a reasonable approximation of this cohort's risk characteristics. Humana Individual membership was used to model the risk of members renewing in 2014. The recoveries in column E of Exhibit 1 are a blend of these two populations. Paid claims were calculated for each member based on their allowed claims and the plan selected in the simulation. As specified by HHS, recoveries were calculated for members with total calendar year claims exceeding the $60,000 attachment point. The recoveries apply an 80% coinsurance rate up to a cap of $250,000.

To ensure statistical credibility, the estimate was calculated using nationwide membership and experience. However, the Colorado specific estimate was calculated by adjusting the nationwide allowed claims for the unit cost differences in Colorado.

A portion of reinsurance recoveries are offset by the reinsurance assessment of $5.25 PMPM. We expect recoveries net of assessments to be $23.05 PMPM which results in a -9.8% adjustment to premium. In compliance with rating rules, all plan premiums are adjusted uniformly by -9.8% as demonstrated in column I of Exhibit 1.

Note that the Unified Rate Review template contains reinsurance recoveries net of assessments wherever reinsurance estimates are requested. This approach was selected because it allows the values in Worksheet 2a to tie back to values from Worksheet 1. The value of reinsurance recoveries can be obtained by adding $5.25 PMPM to each estimate.

Induced Utilization

In this context, Induced Utilization refers to the utilization impact of member behavioral changes when on a plan with richer benefits. This metric does not include the impact of health status.

The induced utilization assumption of 0.9% was developed by applying adjustments to the plan specific factors provided by HHS in the Notice of Benefit and Payment Parameters.

We anticipate the effect of induced utilization to be somewhat less than the original factors suggest, so we have adjusted the factors lower. It is important to note that the assumed impact only accounts for the incremental induced utilization in excess of the induced utilization observed on an average pre-reform plan. This approach is used to avoid double-counting the impact of induced utilization.

Catastrophic versus Non-Catastrophic Allowed Claims

Federal rating rules allow issuers to adjust the index rate for the level of gross claim costs anticipated for Catastrophic plan enrollees. Column B of Exhibit 2 shows allowed claims for the simulated members on Catastrophic and Metal plans. The simulation strictly adheres to the Catastrophic plan eligibility rules and uses member utility to determine plan selections. In the simulation, members eligible for subsidies tend to select Silver plans rather than Catastrophic plans. In addition, less healthy members tend to select plans with richer benefits than the Catastrophic plan. This results in a significantly lower allowed cost for members selecting the Catastrophic plan.

The ratio of Catastrophic allowed claims to total allowed claims across all plans (column C) is used to adjust the overall index rate for Catastrophic plans. This is a -28.3% adjustment to the index rate.

Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust index rate used for Metal Plans and results in a 2.3% adjustment. This small adjustment for Metal plans is necessary to ensure the overall index rate for the single risk pool remains unchanged.

Non-Benefit Expenses and Profit Risk

Expenses are based on our internal forecast for 2014. Expenses are estimated based off of current costs, projected volume changes and estimated changes in department workload. These expenses are simply loaded as a flat percentage of premium at this point in time and do not vary by product or plan.

16.8% Administrative Expense Load

- Broker & Sales Commissions: Compensation expenses associated with business issued through an agent or agency
- Quality Expenses: Expenses associated with quality that are allowed adjustments under the Medical Loss Ratio standards
- Clinical & Network Operations: non-quality clinical costs, provider contracting, and network maintenance & development
- IT Expenses: costs associated with maintenance and development of systems
- Customer Service & Account Installation: call center, customer service, and account management
- Corporate Administration: shared functions that are not exclusive to individual major medical, including corporate finance, legal, human resources, etc.
- Individual Administration: functional areas & personnel that solely work on individual major medical
- Direct Response, Marketing, & Agency Management: direct to consumer marketing expenses, other marketing expenses and agency management expenses

3.1% Profit (or Contribution to Surplus) & Risk Margin

- Profit margin is shown on a post-income tax basis and does not include investment income. The margin shown does not vary by product or plan.

5.1% Taxes and Fees

0.3% • State Premium Tax: state premium tax; charged on a percentage of premium

1.4% • Health Insurer Annual Fee: assessment created in 2014 by PPACA. Estimated at 1.4% of premium. Not income tax deductible.

0.9% • Exchange Fee: charged on a percentage of premium basis to fund the exchange

0.1% • Other Misc Taxes: includes state licensing fees & the Federal Comparative Effectiveness Tax

2.5% • Income Tax: Federal income tax. Estimated as 36% times the sum of pretax profit margin and the non-deductible Health Insurer Annual Fee

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is at least 80%.

Demonstration:

(2014 Claims/2014 Premium) + (Quality Expenses as a % of Premium))/(1 - Taxes and Fees as a % of Premium)

((99,249,732 / 132,385,931) + 1.2%)/(1 - 5.1%) = 80.3%

Index Rate

The index rate for the experience period is simply the allowed claims per member per month in 2012 for all non-grandfathered plans. An adjustment is made to remove the impact of non-EHB state mandated benefits from the experience period allowed claims (see below for details); it is implicitly assumed that all other allowed claims for 2012 were for essential health benefits.
The index rate for the projection period is the credibility manual weighted allowed claims per member month multiplied by the proportion of allowed claims associated with essential health benefits, thereby excluding state mandated covered benefits and other covered benefits in excess of essential health benefits.

State mandated covered benefits that are included in allowed claims but excluded from the index rate include home health care services and physical, occupational, and speech therapy for congenital defects.

Covered benefits in excess of essential health benefits and state mandates that are included in allowed claims but excluded from the index rate include chiropractic care, organ transplants, and routine footcare.

The following market-wide adjustments are applied to the projected index rate as the first step in determining plan level “index” rates:

1) Adjustments for the net impacts of both risk adjustment and reinsurance. See "Risk Adjustment and Reinsurance" earlier section for more details of this market-wide adjustment.

2) An adjustment for the anticipated cost of exchange user fees.

The user fee cost of 1.4% of premiums has been applied to the estimated percentage of 2014 premiums from membership enrolled on the exchange.

It is included in the development of the overall index rate adjustment for this legal entity in this state.

3) Expense estimates (excluding exchange user fees) were based on our internal forecast for 2014. They were estimated based on current costs, modified to accommodate projected volume changes and changes in department workload. These are presented as a flat percentage of premium at this point in time and do not vary by product or plan, and thus are essentially another market-wide adjustment applied to the projected index rate.

4) An adjustment for the addition of non-EHB benefits (additional benefits we provide at our own discretion, as well as any state mandated benefits not reflected in the benchmark plan – typically individual market only mandates). It is assumed that the addition of such benefits increases costs to all plans uniformly, hence it is essentially handled as a market-wide adjustment.

Then the following plan-specific adjustments are applied to determine plan level “index” rates:

5) The individual plan tier pricing actuarial values (AVs) were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. The data used to produce the HumanaOne pricing AVs was based on a standard population of commercially insured membership purchased from a third party vendor. In order to provide the level of detail necessary for the analysis, internal data was used to subdivide the claims experience but the overall utilization level was calibrated to a standard population derived from a multitude of commercial insurers across a broad geographic area. Using this data, a seriatim (member-by-member) model was developed with the standard population data and projected 2014 annual claims by benefit category. Then, the 2014 plan design parameters were applied to those allowed claims to produce paid claims and pricing AV’s. These values were developed in accordance with generally accepted actuarial principles and methodologies.

The resulting plan-specific AV relativity to the overall AV across all plans is applied to the index rate to account for the plan-specific differences in AV and cost sharing.

6) The development of the index rate includes the anticipated average unit costs derived from the provider networks that will be available on this legal entity in this state. These average unit costs are the result of charge levels, network discounts, delivery system characteristics and utilization management practices across the entire state, for this legal entity.

As permitted, an adjustment is made to each plan rate to account for the specific cost differences from each provider network, in each allowed rating area, compared to the overall average across all plans.

Finally, with respect to Catastrophic plans, the following adjustments are made:

7) The ratio of Catastrophic allowed claims to total allowed claims across all plans is used to adjust the overall index rate for Catastrophic plans (reference the previous section on Catastrophic plans for more detail).
8) Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust the index rate used for Metal Plans to ensure the overall index rate for the single risk pool remains unchanged (again, please reference the previous section on Catastrophic plans for more detail).

AV Metal Values

The AV Metal Values indicated in Worksheet 2 of the Part 1 Unified Rate Review Template were determined using the AV Calculator for all new plans.

AV Pricing Values

The fixed reference plan used as the basis for the AV Pricing Values in Worksheet 2 is: Humana Connect Silver 4600/6300 Plan.

Membership Projections

In determining anticipated membership, two internally developed models are used. The first projects overall membership volume based on anticipated market growth, in-force persistency, and relative competitiveness. The second functions independently and produces specific plan tier mixes based on consumer selection behaviors. These two elements are combined to produce the projected membership volumes by plan tier found in Worksheet 2 of the Unified Rate Review Template. Each is described in further detail in Parts I & II, below.

Part I

In projecting overall membership volume across the state, we start with today's estimated total statewide market size and market shares by carrier (based on 2011 SHCE). Along with Humana, the model considers three other "carriers" in the state, two of which are based on the major carriers in the market today and a third which represents the balance of the market. Assumed competitive price relativities are then used to derive a percentage share of 2014 sales by carrier. We believe using these price relativities as the primary determinant of sales share in our modeling to be appropriate, due to increased sensitivity to price in the 2014 marketplace.

Due to the changes occurring in 2014 (guaranteed issue requirements, individual mandate, etc.), the model also makes assumptions for the growth and disruption that will transpire.

We assume the individual market in this state will grow by a factor of 1.70 relative to current market size and that 15.0% of in-force membership will lapse to seek coverage under the new market rules.

These assumptions were set globally across all modeled carriers in the state, given the limited carrier-specific information available at this time.

Together, these market size growth and lapse assumptions create an initial 2014 membership base on which the previously developed sales shares by carrier are applied to create membership sales volume estimates. All sales are assumed to occur on January 1, 2014, thus creating 12 months of exposure for each sold member.

The resulting total exposure created by these sales for Humana is projected to be 563,479 member months (a) on the Humana Health Plan, Inc. legal entity.

Part II

For the purposes of further projecting this membership by individual plan tier, a simulation was developed to model consumer behavior with regard to risk aversion, utility, and affordability. In particular, it considers eligibility for the various premium and cost sharing reduction subsidies by applying a single assumed nationwide income distribution (as a percent of FPL). Internal nationwide small business claims and membership data was used in developing the simulated population, since we believe this experience base provides the best available approximation of the anticipated 2014 risk pool. In general, the simulation assumes that members eligible for cost sharing reductions, based on their income relative to the federal poverty level, are expected to significantly tend toward choosing the applicable silver variant plan, due to its relative value proposition. This tendency becomes less pronounced as the percent of FPL increases.

Member month projections by plan tier (including the CSR silver plan variants) are produced by combining the results of Parts I & II with the developed information detailed above. The results are summarized below:

Plan Tier	Projected Member Months	Percent of Total
Catastrophic	42035	7%
Bronze	241481	43%
Silver	229907	41%
Gold	33459	6%
Platinum	16597	3%
Total	**563479**	**100%**

CSR Variant	Projected Member Months	Percent of Total
70%	122003	22%
73%	24416	4%
87%	49796	9%
94%	33692	6%
Silver Total	**229907**	**41%**

We expect the distribution of our business to shift within the state in direct response to the changes in provider and network deals, and therefore anticipated competitive position, by market. Sales in 2014 will concentrate in areas where there have been the most pronounced improvements; in the absence of such improvements, the geographic distribution across the state is expected to remain relatively constant from the current to the projection period. This is accounted for in the modeling methodology described above.

Terminated Products

HIOS Entity Name	State	Issuer ID	Product Smart ID	Product Name
Humana Health Plan	CO	74320	74320CO035	HumanaOne PHP Refresh
Humana Health Plan	CO	74320	74320CO049	HumanaOne HMO
Humana Health Plan	CO	74320	74320CO060	HumanaOne HMO

Effective Rate Review Information

URR Approach

This section describes how the URR template values were populated in instances where the instructions were unclear or the template's functionality was unable to accommodate the appropriate values.

- Rate change % over prior filing (row 25) was populated with the change between rates effective 1/1/2014 and rates effective 12/31/2013. The previous rate filing contained rates that were effective through the end of 2013. Therefore, the 2014 rate is compared to the last rate in effect on 12/31/2013.
- Cumulative Rate Change % over 12 months prior (row 26) was populated with the change between rates effective 1/1/2014 and rates effective 1/2/2013. This captures the change in the rates over precisely one year.
- Projection Period Rate Change % over Experience Period (row 27) is a calculated formulaically by the template. However, it is important to note that this measure can be subject to significant variability. In our 2014 projection we assume a constant distribution of membership by age and geography. The rates for each plan were developed using the same distribution and is reflected in the average premiums (row 80). However, in row 27 this is compared to earned premiums from the experience period. The experience period will have a significantly different distribution of membership by age and geography than in the projection. As a result, row 27 will reflect changes in mix as well as changes in rates. This results in significant volatility for plans with limited membership during the experience period.
- Section IV of Worksheet 2 contains several inconsistencies between the calculated rows and the warning checks. These inconsistencies are primarily due to the definition of Total Allowed Claims (row 86). The warning check and the template instructions both indicate that the impact of reinsurance and risk adjustment should be included in Total Allowed Claims. However, formulas that refer to row 86 use it as if the impact of reinsurance and risk adjustment were not included. This results in double counting and inappropriate application of these items in rows 93, 98 and 99. Our approach was to follow the template instructions when populating row 86 and then explain the warnings that get generated in the subsequent rows. Explanations for the warnings can be found later in the memorandum.
- The net impact of risk adjustment (row 96) does not accept negative values if entered manually. However, we have found that populating this row via copy/paste will validate successfully. Therefore we have populated the template using this technique when necessary.

Warning Alerts

Worksheet 1, Rows 24-29, Column K:

Warnings have been generated in rows 24-29, column K for the 'other' adjustment. We expect a net reduction in rates for the adjustments embedded in this column and therefore a value less than 1.0 is being applied. Details of the components of the 'other' adjustment have been described in a previous section.

Worksheet 2, Row 82:

A warning has been generated in row 82. The values in this row are based on the sum each plan's projected premium based on the plan's projected membership and average rate pmpm. The warning in row 80 allows for a 2% tolerance level when comparing to the value depicted on Worksheet 1, but the Worksheet 2 tolerance level requires equivalence. This slight variation makes a perfectly equivalent premium match highly unlikely. The worksheet 2 results are within a tolerable range of the worksheet 1 value.

Worksheet 2, Rows 83-85:

A false error is populating for rows 83-85 in all columns suggesting the three values do not add to 100%. This is incorrect; based on the formula in row 85, it is impossible for this to be true. Values have been appropriately populated.

Worksheet 2, Rows 93, 98, 99:

Warnings have been generated in rows 93, 98, and 99 for the same reason. The values in these rows are all based on the values in Total Allowed Claims (row 86) and per the template instructions this includes the impact of reinsurance and risk adjustment. This is inconsistent with how this value is used by template formulas and comparisons to values on Worksheet 1. Rows 93 and 98 are calculated based on row 90 which includes the impact of reinsurance and risk adjustment. Row 90 is subtracted from row 86 causing the impact of reinsurance and risk adjustment to be double counted. Warnings are generated when these numbers are compared to values from Worksheet 1 that include these impacts properly. In addition, Row 99 is calculated based on row 86 (which includes reinsurance and risk adjustment), but validated using a value from Worksheet 1 that does not include reinsurance and risk adjustment.

Reliance

I, Stephen Arnhold, relied on information and underlying assumptions provided by internally developed pricing and modeling as well as third party consultant data in the establishment of these rates.

Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify, to the best of my knowledge, that the projected index rate is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), developed in compliance with the applicable Actuarial Standards of Practice, reasonable in relation to the benefits provided and the population anticipated to be covered, and neither excessive nor deficient.
I certify, to the best of my knowledge, that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
I certify, to the best of my knowledge, that that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.
I certify, to the best of my knowledge, that that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

This opinion is qualified, in that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Actuary signature: 

Actuary Printed Name: Stephen Arnhold, FSA, MAAA

Date: May 14, 2013

Colorado
Humana Health Plan, Inc.
Exhibit 1
Pricing Impacts of Risk Adjustment and Reinsurance

Values are projected based on current membership and simulated 2014 enrollees

	A	B	C	D	E	F	G = D - E - F	H = G / Tgt LR*	I = - E / H	J = - F / H
	% of Members	**% Underwritten**	**Plan Liability Risk Score**	**Paid Claims PMPM**	**Net Reinsurance PMPM**	**Risk Adjustment Transfer Payment PMPM**	**Total Liability PMPM**	**Premium PMPM**	**Reinsurance % of Premium**	**Risk Adjustment % of Premium**
Catastrophic	8%	18%	0.575	147.90	17.10	0.10	130.70	174.26	-9.8%	-0.1%
Metal Plans	92%	22%	0.963	224.71	23.54	21.22	179.95	239.94	-9.8%	-8.8%
Bronze	42%	23%	0.685	205.41	21.52	19.39	164.49	219.33	-9.8%	-8.8%
Silver	41%	21%	1.091	232.94	24.40	21.99	186.55	248.73	-9.8%	-8.8%
Gold	6%	20%	1.524	265.69	27.83	25.09	212.77	283.69	-9.8%	-8.8%
Platinum	3%	18%	1.971	299.55	31.38	28.28	239.89	319.85	-9.8%	-8.8%
HHP Total	12%	21%	0.933	218.78	23.05	19.52	176.21	234.95	-9.8%	-8.3%
Other Issuers	88%	45%	0.836			(2.63)		284.35		
CO Total	100%	42%	0.848			0.00		278.49		

*Target Loss Ratio: 1 - administrative load - profit/risk load - taxes/fee load. Loads provided in Worksheet 1.

***Special Note**: The above exhibit reflects the final pricing used in developing the rates proposed in this submission. Late-breaking guidance was given to discontinue existing products in this legal entity, and due to time constraints we were not able to incorporate said guidance into the final pricing; however, we do not believe this to result in a material change to the final rates as submitted.

We were able to revise our projected sales and membership to reflect this guidance, which is why there is a slight inconsistency in the membership weights shown above and in the "Membership Projection" section of the accompanying memorandum.

Colorado
Humana Health Plan, Inc.
Exhibit 2
Catastrophic/Non-Catastrophic Index Rate Adjustment

	A	B	C	
	% of Members	Allowed Claims PMPM	Index Rate Adjustment	
Humana - HHP	12%	360.46	1.000	
Catastrophic	8%	258.55	0.717	= 258.55 / 360.46
Metal Plans	92%	368.61	1.023	= 368.61 / 360.46
Bronze	42%	368.61	1.023	= 368.61 / 360.46
Silver	41%	368.61	1.023	= 368.61 / 360.46
Gold	6%	368.61	1.023	= 368.61 / 360.46
Platinum	3%	368.61	1.023	= 368.61 / 360.46

*__Special Note__: The above exhibit reflects the final pricing used in developing the rates proposed in this submission. Late-breaking guidance was given to discontinue existing products in this legal entity, and due to time constraints we were not able to incorporate said guidance into the final pricing; however, we do not believe this to result in a material change to the final rates as submitted.

We were able to revise our projected sales and membership to reflect this guidance, which is why there is a slight inconsistency in the membership weights shown above and in the "Membership Projection" section of the accompanying memorandum.

STATE OF COLORADO
HUMANA HEALTH PLAN, INC.
ACTUARIAL MEMORANDUM
POLICY FORM SERIES CO-71130-POS & CO-71129

A. Summary

1. Purpose

We respectfully submit for your consideration the enclosed premium rates for use with the above captioned policy series. This actuarial memorandum was created and formatted pursuant to Colorado Regulation 4-2-11, Section 6.

This filing has been prepared for the purpose of certifying that the anticipated loss ratio of this product meets the minimum requirement of this state, assuring that rates are reasonable in relation to the benefits provided, as well as demonstrating rates are not excessive, inadequate, or unfairly discriminatory. It is not intended to be used for any other purpose.

2. Requested Rate Action

This is a new product; therefore there is no requested rate action.

3. Marketing Methods

The policy will be marketed by general agents, brokers, wholesale arrangements, and by Humana employees through various campaigns geared directly to consumers. A suite of plans included in policy form series, CO-71129 will be offered both on and off the exchange. The remaining plans will be offered off exchange exclusively.

Previously approved form series under the Humana Health Plan entity, CO-71037-POS, will be discontinued beginning 1/1/2014. Members will receive necessary notification and the opportunity to purchase any of the plans included in this filing.

4. Premium Classifications

Premium rates vary by combination of age (as of issue for new business and attained age for renewals), tobacco usage, geographic area, and family composition. These associated factors can be found in the attached rate manual.

5. Product Description

This is an Individual Major Medical plan sold and renewed to individuals and families. The rates under policy form series, CO-71130-POS, support a Point-of-Service plan provided through a dual entity POS contract with Humana Health Plan, Inc. and Humana Insurance Company. The dual entity POS contract communicates both network and non-network benefits to a member in a single policy. The member has open access to network HMO providers as referrals are not required. The network supporting this product is a combination of both HMO and PPO network providers, affording members with access to a larger provider network.

The rates under policy form series, CO-71129, support a Health Maintenance Organization plan provided through an HMO contract with Humana Health Plan, Inc. Indemnity benefits on these policy series are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred.

The plans under policy series CO-71120-POS include our embedded Wellness & Rewards Program, HumanaVitality. The premium impact of this embedded benefit is 1%, approximately $2.40 PMPM. Pursuant to § 10-16-136(3.7), C.R.S., Humana received national accreditation from the National Committee of Quality

Assurance on September 11, 2012 (attached certification and letter under Supporting Documents Tab). Furthermore, please see the Supporting Documents Tab for documentation demonstrating that the wellness program is scientifically proven to improve health (Regulation 4-2-11 7.B).

All non-grandfathered plans must cover the essential health benefits package in 2014. The specifics of the essential health benefits are contained within the benchmark plan selected in each state. There are 3 high level categories of benefits that are considered from a pricing perspective for the individual market: (1) maternity, (2) behavioral services and (3) other state-specific services. For the pricing impact of these 3 benefits, please see section J below.

The following PPACA benefits have been implemented in all of our non-grandfathered business,

- Eliminate Annual Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
- Eliminate Lifetime Dollar Limits on Essential Benefits, Section 2711 of the PHSA/Section 1001 of the PPACA
- Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19, Section 2711 of the PHSA/Section 1201 of the PPACA
- Prohibit Rescissions, Section 2712 of the PHSA/Section 1001 of PPACA
- Preventive Services, Section 2713 of the PHSA/Section 1001 of the PPACA
- Extends Dependent Coverage for Children Until age 26, Section 2714 of the PHSA/Section 1001 of the PPACA
- Appeals Process, Section 2719 of the PHSA/Section 1001 of the PPACA
- Emergency Services, Section 2719A of the PHSA/Section 10101 of the PPACA
- Access to Pediatricians, Section 2719A of the PHSA/Section 10101 of the PPACA
- Access to OB/GYNs, Section 2719A of the PHSA/Section 10101 of the PPACA

A summary of key benefit can be found in the rate manual, along with the rating factors associated with the plans; the policy form should be consulted for specific benefit provisions.

6. Age Basis

Premiums will be calculated using age at issue for new business and attained age for renewing business.

B. Assumption or Acquisition

All plan designs have been developed internally and are not part of an assumption or acquisition.

C. Rating Period

The effective date of the rating period is January 1, 2014 for all plan designs. Rates are effective until 1/1/2015, at which point members issued during 2014 will have their rate potentially modified.

D. Underwriting

All membership is intended to be issued without underwriting.

E. Effect of Law Changes

This rate filing was prepared to support the law changes mandated as a result of the Affordable Care Act. A detailed description of the impacts can be found in section J.

F. Rate History

CO-71129 and CO-71130-POS are new policy form series, therefore no rate history can be provided.

G. Coordination of Benefits

Coordination of benefits data is included in the loss ratio calculation.

H. Relation of Benefits to Premium

Below is a summary of the retention estimate used for pricing this product. Note that investment income is not included, as it is not expected to be a material contribution to the profitability of this product.

Expense Category	**% of Premium**
Broker & Sales Commissions	4.40%
Quality Expenses	1.20%
Clinical & Network Operations	1.90%
IT Expenses	1.00%
Customer Service & Account Installation	1.60%
Corporate Administration	2.40%
Individual Products Administration	2.70%
Direct Response, Marketing, & Agency Management	1.60%
State Premium Tax	0.30%
Health Insurer Annual Fee	1.40%
Exchange Fee	0.90%
Other Misc Taxes & Assessments	0.10%
Income Tax	2.50%
Total Administrative Expense	**21.90%**
Loss Ratio	75.00%
Post-Tax Risk Margin/Profit	3.10%

I. Provision for Profit and Contingencies

The provision for profit and contingencies is 3.1% post-FIT. Because we do not anticipate holding policy reserves on this business, investment income only is obtained by returns on unearned premium reserves and reserves for incurred but not reported claims. We do not know the timing of when we will receive the advanced premium tax credits from the federal government. We anticipate that the unearned premium reserve may be offset by payment delays from the federal government. Therefore, we expect investment income to be a negligible source of revenue for this product line.

J. Complete Explanation as to How the Proposed Rates were Determined

The original premiums for this policy form series were developed using experience from existing policy forms by adjusting for benefit differences, expense differences and any other rating differences. Premium rates were developed so that the ratio of claims to premium would produce a reasonable lifetime loss ratio, not less than any minimum required in this state.

The form series, CO-71037 was used as the basis for the pricing for 2014. This represents the current new business product available for purchase throughout the state. The overall rates were adjusted for additional essential health benefits, trend between the 10/1/2013 premium basis and 1/1/2014, guaranteed issue, expected network improvements, differences in allowed rating factors, 10/1/2013 pricing adequacy, marginal taxes & fees, and the expected net impact of reinsurance and risk adjustment.

Details are as follows:

- Essential Health Benefits
  - Maternity
    - Estimated at 0.0% impact. This benefit is already covered in our individual plans today.
  - Behavioral Services
    - Estimated at 0.6% impact. This estimate was produced using small group allowed claims as a percentage of overall claims and adjusting the incidence rate for the expected FPL mix.
  - Other Misc
    - Other essential health benefit impacts estimated at 0.6%.
- Trend
  - 1.3% impact to go from the midpoint of the 10/1/2013 rating period to 1/1/2014. Please see the attached exhibit.
- Guaranteed Issue
  - Estimated 62.0% impact. Based on comparison of our own small group claims from the 2-50 market, consultant estimates, and an estimate of the total market mix between previously underwritten individuals and newly issued.
- Network Improvements
  - We were able to achieve significant estimated savings in Denver and Colorado Springs by changing from the current POS network to new HMO networks. Savings are reflected in the area factors and value at approximately -27.8%. (For new business on exchange only.)
- Allowed Rating Factor Differences
  - Estimated 4.0% impact for the removal of durational rating.
  - Estimated 8.3% impact for the removal of underwriting rate ups.
  - Estimated 0.7% impact for capping the number of dependents at 3
- Current Pricing Adequacy Adjustment
  - Estimated -4.6% impact for adequacy of current rates. Developed using projected 2013 loss ratio compared to target loss ratio, adjusted for rate actions through the year to determine 10/1/2013 adequacy.
- Marginal Taxes & Fees
  - New federal health insurer annual fee is estimated at 2.1% of premium (this includes the gross up for this fee not being tax deductible).
  - Exchange user fee is estimated at 0.9% of premium in total.
- Net Impact of Reinsurance and Risk Adjustment
  - Total adjustment for reinsurance payment & risk adjustment payment is estimated at -18.7%

K. Trend: Cost & Utilization

The cost trend captures pure unit cost changes from midpoint 2012 to midpoint 2014, calculated using the same basket of services each period, due to price/contract negotiations and provider distribution changes.

Inpatient Hospital, Outpatient Hospital, Professional, Capitation and Other Medical cost trends are developed based on historical area specific cost trends from Humana's Individual Commercial block of business data. Future cost trends are developed based on expected changes in Humana's Commercial contracts. Pharmacy cost trends are developed based on historical brand, generic, and specialty drug trends from Humana's Commercial data. Future cost trends are developed based on expected changes in these pharmacy contracts. These contractual impacts will be applicable to all members regardless of risk class.

Utilization trend:
Using Humana's Trend Quantification and Projection model, a baseline utilization trend is developed using Humana's Individual Commercial block of business historical medical claims data from 2008 - 2012. The historical baseline utilization trend is developed by removing all known impacts to utilization net trend such as demographics, geography, duration, customer changes, benefit changes, new health technologies, utilization management initiatives, and changes in pertinent days. An economic regression model, based on consumer sentiment, personal disposable income, hospital construction, and high-tech medical equipment spend, is then fit

to this historical baseline utilization data to project the future block of business baseline utilization trend for 2013 and 2014.

A midpoint to midpoint methodology is applied to determine the applicable baseline utilization trend, which incorporates 2012q3 and 2012q4 actual results at the state and legal entity level with the block of business baseline utilization trend for 2013 and 2014. This results in baseline utilization trends that vary at the state and legal entity level.

Other components are added to the baseline utilization trend to develop the total utilization trend provided. These include the following:

- Pertinent days – Captures changes in the calendar, recognizing that health care utilization varies by day of the week and reporting periods contain varying weekday mix and count. This impact is developed through the use of an external consultant's model which is uploaded with Humana's Commercial claims data.

- New Health Technologies – Captures the impact of new health technologies and procedures. An external consulting firm researches new technologies and develops per member per month impacts. These impacts are customized to Humana's Commercial business based on membership and coverage policy.

- Management Initiatives – Captures savings for Humana initiatives designed to bend trend by managing utilization, such as case management, disease management, and nurse programs. These initiatives are evaluated by an internal actuarial organization tasked with evaluating the effectiveness of the initiatives. Evaluations are done through a collaborative effort involving clinical and other operational areas. Projected savings are calculated by determining prospective changes to impacted metric values, which are determined by analyzing historical metric values as well as through discussions with clinical and operational areas. Savings are reviewed with leadership to ensure appropriateness of assumptions.

This describes the development of the core utilization trend. All impacts from healthcare reform have been removed and are included in the "Population Risk/Morbidity" and "Other" adjustments from URR Worksheet 1 to prevent double counting of any impacts.

For additional detail, please see the attached trend exhibits, Exhibit B.

L. Credibility

To credibility adjust this block of business, a credibility manual consisting of slight modifications to 2014 market projections was utilized. Source data utilized for the credibility manual calculation includes Colorado Humana Health Plan, Inc. utilization per 1000 that mirrors the 2014 projected experience, adjusting to reflect the overall credibility of the block of business that we apply in pricing to ensure adequacy of rates.

The average cost per service is driven by the Colorado Humana Health Plan, Inc. 2014 projected experience in order to maintain representation of the provider contracts and distribution mix represented in the allowed claim derivation, also adjusted to reflect the credibility of the block of business to ensure pricing adequacy.

The state of Colorado has mandated a level of 24,000 member months for full credibility. Per that mandate, our credibility weight methodology has been adjusted to reflect utilizing the following equation: square root(member months in experience period/24000). To account for the presence of Colorado Humana Health Plan, Inc. experience in the credibility manual, the credibility level afore mentioned has been reduced by a factor of the expected 2014 membership relative to nationwide.

We do not expect to have services in the projection period provided under a capitation arrangement.

M. Data Requirements

Please see the attached past and future projection exhibit, Exhibit A.

N. Side-by-Side Comparison

The proposed rates on policy form series CO-71129 & CO-71130-POS are new. Therefore, there is no comparison between current rates and proposed rates.

O. Benefits Ratio Projections

Benefit projection ratio is projected to be 75%. This includes the effects of reinsurance and risk adjustment. Please see projection exhibit for details. For your reference, Actuarial Justification has been provided via attachment, 2014 CO HHP Justification of Benefit Ratio.

P. Other Factors

See attached rate manual.

Q. Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify that this rate filing adheres to the laws of this state, to the best of my knowledge. I further certify that the assumptions used to develop rates are reasonable, that they have been set with an understanding of the business plan for this form series, and that they produce rates that are not excessive, inadequate or unfairly discriminatory.

Stephen Arnhold, FSA, MAAA
Actuarial Director, Individual Product Segment
June 5, 2013

Exhibit B1: HumanaOne Trend Estimate

Service Month	End of Month Member Count	Paid Medical Claims	IBNR Medical Reserves	Total Incurred Medical Claims	Paid Rx Claims	Total Incurred Claims	Raw PMPM Claims (A)	Relative Exp LR (B)	Relative Age Factor (C)	Relative Area Factor (D)	Relative Plan Factor (E)	Adj PMPM Clms (A)/(B*C*D*E)	YoY Trend Raw	YoY Trend Adjusted
4/1/2010	9	0	0	0	0	0								
5/1/2010	169	1,629	0	1,630	1	1,631								
6/1/2010	872	12,034	1	12,035	20	12,055								
7/1/2010	1,381	31,415	3	31,417	88	31,505								
8/1/2010	1,859	65,103	6	65,109	1,367	66,476								
9/1/2010	2,685	92,028	9	92,036	1,438	93,474								
10/1/2010	3,883	225,045	40	225,086	6,574	231,659								
11/1/2010	4,683	265,071	48	265,119	9,032	274,151								
12/1/2010	6,480	285,514	59	285,573	8,108	293,681								
1/1/2011	6,722	272,337	76	272,413	5,810	278,223								
2/1/2011	7,373	380,852	119	380,971	10,685	391,656								
3/1/2011	8,632	880,832	344	881,176	14,449	895,625	57.44	1.000	1.000	1.000	1.000	57.44		
4/1/2011	9,547	836,449	420	836,869	11,516	848,386	62.97	1.013	1.003	0.999	1.001	61.95		
5/1/2011	10,795	767,144	531	767,675	12,907	780,582	64.66	1.026	1.006	0.998	1.001	62.70		
6/1/2011	11,687	806,486	590	807,077	13,230	820,307	66.10	1.040	1.010	0.998	1.001	63.04		
7/1/2011	12,300	882,364	769	883,133	68,851	951,984	68.40	1.053	1.013	0.997	1.001	64.29		
8/1/2011	13,179	869,881	831	870,712	22,837	893,549	68.93	1.065	1.014	0.996	1.001	64.02		
9/1/2011	13,937	1,481,144	1,742	1,482,886	25,752	1,508,638	74.79	1.076	1.016	0.996	1.001	68.63		
10/1/2011	14,600	1,375,224	2,100	1,377,324	46,836	1,424,160	78.05	1.083	1.017	0.995	0.999	71.22		
11/1/2011	15,340	1,802,167	3,187	1,805,355	40,167	1,845,522	83.71	1.090	1.019	0.995	0.998	75.97		
12/1/2011	16,623	1,568,892	2,823	1,571,715	61,071	1,632,785	87.20	1.096	1.020	0.994	0.996	78.74		
1/1/2012	17,472	1,098,760	4,530	1,103,290	11,913	1,115,202	86.53	1.101	1.022	0.994	0.994	77.85		
2/1/2012	18,482	1,268,737	5,207	1,273,944	19,762	1,293,706	86.17	1.106	1.023	0.994	0.992	77.29		
3/1/2012	19,827	1,411,861	12,015	1,423,875	23,350	1,447,225	83.79	1.111	1.024	0.994	0.990	74.94	45.9%	30.5%
4/1/2012	20,487	1,477,002	11,713	1,488,715	37,888	1,526,604	82.50	1.115	1.025	0.994	0.988	73.58	31.0%	18.8%
5/1/2012	21,073	2,512,138	25,283	2,537,422	56,437	2,593,859	87.45	1.120	1.026	0.993	0.985	77.74	35.2%	24.0%
6/1/2012	21,900	2,792,827	31,784	2,824,611	54,627	2,879,238	93.13	1.125	1.026	0.993	0.983	82.54	40.9%	30.9%
7/1/2012	22,287	1,814,652	32,871	1,847,523	53,587	1,901,109	93.22	1.131	1.028	0.993	0.981	82.30	36.3%	28.0%
8/1/2012	22,919	3,397,960	85,093	3,483,053	67,982	3,551,035	101.00	1.136	1.029	0.993	0.979	88.80	46.5%	38.7%
9/1/2012	23,635	2,214,939	131,522	2,346,462	67,186	2,413,648	100.68	1.142	1.031	0.993	0.977	88.12	34.6%	28.4%
10/1/2012	23,591	2,439,961	164,078	2,604,040	105,153	2,709,193	102.24	1.148	1.033	0.993	0.975	89.06	31.0%	25.0%
11/1/2012	23,763	2,499,093	307,018	2,806,111	103,033	2,909,144	103.04	1.155	1.035	0.993	0.972	89.32	23.1%	17.6%
12/1/2012	24,175	2,216,203	503,082	2,719,285	118,887	2,838,173	104.69	1.162	1.037	0.993	0.970	90.27	20.1%	14.6%
1/1/2013	23,942	1,244,546	561,006	1,805,552	47,439	1,852,990	104.92	1.169	1.039	0.992	0.968	89.93	21.2%	15.5%
2/1/2013	24,182	485,465	1,153,358	1,638,823	50,464	1,689,287	104.17	1.177	1.041	0.992	0.965	88.76	20.9%	14.8%
											Yellow Cell Average		34.2%	25.5%

Notes:
(A) Data shown is paids through February
(B) Rx claims are assumed complete
(C) Only includes non-grandfathered business on both HIC & HHP

Exhibit B2

Annual Trend Estimates by Service Category

		Cost					Utilization				
Quarter	Weight	Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Prescription Drug	Inpatient Hospital	Outpatient Hospital	Professional	Other Medical	Prescription Drug
2012q4	4%	0.0%	4.3%	2.1%	0.8%	9.9%	-1.3%	92.9%	126.3%	557.0%	66.8%
2013q1	8%	3.5%	4.5%	0.8%	0.8%	9.5%	-1.8%	6.2%	0.5%	16.5%	2.8%
2013q2	11%	3.5%	4.4%	0.8%	0.7%	9.5%	-1.8%	5.7%	2.2%	8.4%	2.9%
2013q3	14%	3.8%	4.4%	0.8%	0.8%	9.5%	-1.0%	3.5%	2.3%	0.9%	3.0%
2013q4	13%	3.7%	4.3%	0.9%	0.8%	9.4%	-0.9%	5.1%	0.7%	10.7%	1.7%
2014q1	18%	3.4%	4.0%	1.0%	1.0%	9.1%	0.3%	1.6%	0.9%	2.3%	6.5%
2014q2	31%	3.6%	4.1%	1.0%	1.0%	9.1%	2.0%	3.1%	0.9%	8.5%	5.8%
	Average	3.4%	4.2%	1.0%	0.9%	9.3%	0.0%	7.4%	6.4%	29.8%	7.0%

Notes:

Includes non-grandfathered HHP membership only.

Based on internal trend model

Matches what was used in the URR

Supporting Exhibit: Rate Review Detail (SERFF Requirement)

The purpose of this document is to explain the assumptions used when calculating fields for the rate review detail window in SERFF.

Requested Rate Change Information

Change Period:	Annual		
Member Months[1]:	0		
Benefit Change:	None		
	Min[2]	Max[2]	Weighted Avg[2]
Percent Rate Change Requested:	0.0%	0.0%	0.0%

Prior Rate

Total Earned Premium[3]:	$0		
Total Incurred Claims[3]:	$0		
	Min[4]	Max[5]	Weighted Avg[6]
Annual $:	0	0	0

Requested Rate

Projected Earned Premium[7]:	$132,385,931		
Projected Incurred Claims[7]:	$99,249,732		
	Min[8]	Max[9]	Weighted Avg[10]
Annual $:	84	1,332	235

Notes

(1) Not applicable; this is the initial filing.
(2) Not applicable, this is the initial filing.
(3) Not applicable, this is the initial filing.
(4) Not applicable, this is the initial filing.
(5) Not applicable, this is the initial filing.
(6) Not applicable, this is the initial filing.
(7) Projected over calendar year 2014, including policy reserves.
(8) The Minimum Annual $ is the lowest possible monthly rate per member for standard benefits effective January 1, 2014.
(9) The Maximum Annual $ is the highest possible monthly rate per member for standard benefits effective January 1, 2014.
(10) The Weighted Average Annual $ is the pmpm projected premium on a January 1, 2014 basis.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
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CO-HHP
January 1, 2014
Rate Filing

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Average Premium

$234.95

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Plan Designs & Factors

Plan Name	Plan Suite	Plan Tier	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)	Off-Exchange (includes Ped. Dental)
Humana Connect Basic 6350/6350 Plan	Suite A	Catastrophic	$6,350	100%	$6,350	Integrated	0.7256	0.7285
Humana Connect Bronze 6300/6300 Plan	Suite A	Bronze	$6,300	100%	$6,300	Integrated	0.9132	0.9168
Humana Connect Silver 4600/6300 Plan	Suite A	Silver	$4,600	80%	$6,300	$1,500	1.0356	1.0398
Humana Connect Gold 2500/3500 Plan	Suite A	Gold	$2,500	80%	$3,500	$500	1.1812	1.1859
Humana Connect Platinum 1000/1500 Plan	Suite A	Platinum	$1,000	80%	$1,500	$500	1.3317	1.3371
Humana Connect Bronze 4900/6400 Plan	Suite A	Bronze	$4,900	80%	$6,400	$1,500	0.9843	0.9883
Humana Connect Silver 3650/3650 Plan	Suite A	Silver	$3,650	100%	$3,650	Integrated	1.0505	1.0547
Humana Preferred Basic 6350/6350 Plan	Suite C - Rx4	Catastrophic	$6,350	100%	$6,350	Integrated		0.7603
Humana Preferred Bronze 4900/6400 Plan	Suite C - Rx4	Bronze	$4,900	80%	$6,400	$1,500		1.0269
Humana Preferred Silver 4250/6250 Plan	Suite C - Rx4	Silver	$4,250	80%	$6,250	$1,500		1.0739
Humana Preferred Bronze 6300/6300 Plan	Suite C - Rx4	Bronze	$6,300	100%	$6,300	Integrated		0.9128
Humana Preferred Silver 3650/3650 Plan	Suite C - Rx4	Silver	$3,650	100%	$3,650	Integrated		1.0554

Average Factor	1.0000

Cost Sharing Subsidized Plan Designs

Plan Name	Plan Suite	FPL	Deductible	Coinsurance	Max OOP	Rx Deductible	On-Exchange (no Ped. Dental)
Humana Connect Silver 4600/6300 Plan	Suite A	250+	$4,600	80%	$6,300	$1,500	1.0356
		200 - 250	$3,250	80%	$4,750	$1,000	1.0356
		150 - 200	$900	80%	$1,450	$500	1.0356
		100 - 150	$500	80%	$750	$250	1.0356
Humana Connect Silver 3650/3650 Plan	Suite A	250+	$3,650	100%	$3,650	Integrated	1.0505
		200 - 250	$2,920	100%	$2,920	Integrated	1.0505
		150 - 200	$1,100	100%	$1,100	Integrated	1.0505
		100 - 150	$475	100%	$475	Integrated	1.0505

In addition to the Silver plan variations shown above, all on-exchange metal tier plans will also have a 100% Cost Sharing Plan Design for American Indians/Alaska Natives, and for pricing purposes, will use the plan factors shown in the top table.

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Age Factors

Age of Member	Factor	Demonstration of Compliance Factor compared to age 21
Fourth+ Dependents	0.0000	0.000
0-20	0.5372	0.635
21	0.8461	1.000
22	0.8461	1.000
23	0.8461	1.000
24	0.8461	1.000
25	0.8494	1.004
26	0.8664	1.024
27	0.8867	1.048
28	0.9197	1.087
29	0.9467	1.119
30	0.9603	1.135
31	0.9806	1.159
32	1.0009	1.183
33	1.0136	1.198
34	1.0271	1.214
35	1.0339	1.222
36	1.0406	1.230
37	1.0474	1.238
38	1.0542	1.246
39	1.0677	1.262
40	1.0813	1.278
41	1.1016	1.302
42	1.1210	1.325
43	1.1481	1.357
44	1.1819	1.397
45	1.2217	1.444
46	1.2691	1.500
47	1.3224	1.563
48	1.3833	1.635
49	1.4434	1.706
50	1.5111	1.786
51	1.5779	1.865
52	1.6515	1.952
53	1.7260	2.040
54	1.8063	2.135
55	1.8867	2.230
56	1.9738	2.333
57	2.0618	2.437
58	2.1558	2.548
59	2.2023	2.603
60	2.2962	2.714
61	2.3774	2.810
62	2.4307	2.873
63	2.4976	2.952
64+	2.5382	3.000

Average Factor	1.0000

Humana Health Plan, Inc.
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Tobacco Use Factors

The following factors will be applied based on the member's tobacco usage, as determined by the tobacco usage guidelines.

Age of Member	Non-Tobacco User	Tobacco User	Demonstration of Compliance Factor compared to Non-Tobacco User
0-20	0.9941	0.9941	1.000
21	0.9941	1.0935	1.100
22	0.9941	1.0935	1.100
23	0.9941	1.0935	1.100
24	0.9941	1.0935	1.100
25	0.9941	1.0935	1.100
26	0.9941	1.0935	1.100
27	0.9941	1.0935	1.100
28	0.9941	1.0935	1.100
29	0.9941	1.0935	1.100
30	0.9941	1.0935	1.100
31	0.9941	1.0935	1.100
32	0.9941	1.0935	1.100
33	0.9941	1.0935	1.100
34	0.9941	1.0935	1.100
35	0.9941	1.0935	1.100
36	0.9941	1.0935	1.100
37	0.9941	1.0935	1.100
38	0.9941	1.0935	1.100
39	0.9941	1.0935	1.100
40	0.9941	1.0935	1.100
41	0.9941	1.0935	1.100
42	0.9941	1.0935	1.100
43	0.9941	1.0935	1.100
44	0.9941	1.0935	1.100
45	0.9941	1.0935	1.100
46	0.9941	1.0935	1.100
47	0.9941	1.0935	1.100
48	0.9941	1.0935	1.100
49	0.9941	1.0935	1.100
50	0.9941	1.0935	1.100
51	0.9941	1.0935	1.100
52	0.9941	1.0935	1.100
53	0.9941	1.0935	1.100
54	0.9941	1.0935	1.100
55	0.9941	1.0935	1.100
56	0.9941	1.0935	1.100
57	0.9941	1.0935	1.100
58	0.9941	1.0935	1.100
59	0.9941	1.0935	1.100
60	0.9941	1.0935	1.100
61	0.9941	1.0935	1.100
62	0.9941	1.0935	1.100
63	0.9941	1.0935	1.100
64+	0.9941	1.0935	1.100

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
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Geographic Network Factors

The following factors will be applied according to the policyholder's place of residence.

		Network	
Rating Area	Reference Market Name	HMOx	POS
1	Boulder	-	1.5280
2	Colorado Springs	0.9259	1.2611
3	Denver	0.9573	1.3327
4	-	-	-
5	-	-	-
6	-	-	-
7	-	-	-
8	-	-	-
9	-	-	-
10	-	-	-
11	-	-	-

Average Factor	1.0000

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Plan Distribution

	New Business				Renewal Only	
	On-Exchange		Off-Exchange		Off-Exchange	
	Network		Network		Network	
Plan Suite	HMOx	POS	HMOx	POS	HMOx	POS
Suite A Suite C - Rx4 Refresh PHP	X		X	X		

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
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Definition of Service Areas

Service areas are defined by groups of counties.
For reference only. For complete plan availability, see the Service Area template.

		Network	
Rating Area	Reference Market Name	HMOx	POS
1	Boulder	n/a	Boulder
2	Colorado Springs	El Paso, Teller	El Paso, Teller
3	Denver	Adams, Arapahoe, Broomfield, Denver, Douglas, Jefferson	Adams, Arapahoe, Broomfield, Denver, Douglas, Elbert, Jefferson
4	-	n/a	n/a
5	-	n/a	n/a
6	-	n/a	n/a
7	-	n/a	n/a
8	-	n/a	n/a
9	-	n/a	n/a
10	-	n/a	n/a
11	-	n/a	n/a

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Modal Factors

The following factors will be applied according to the payment mode selected.
These factors will be applied at the end of the rate calculation.

Payment Frequency	Factor
Monthly	1.0000
Quarterly	3.0000
Semi-Annual	6.0000

An administrative fee of $5 will be charged for each paper bill generated and each recurring credit card transaction. The fee is waived for electronic funds transmission (EFT). A $25 fee is charged for checks returned with, or Electronic Fund Transactions resulting in, insufficient funds. A $25 fee is charged for late payment and a $25 fee is charged to reinstate a lapsed policy.

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Algorithm Details

Step through this algorithm for each member.

	Average Premium
x	Plan Factor
x	Age Factor
x	Tobacco Use Factor
x	Geographic Network Factor
=	Subtotal *(rounded to nearest penny)*
x	Modal Factor
=	Rate

Humana Health Plan, Inc.
Suite A HMOx, Suite C NPOS
CO-71129 & CO-71130-POS

Sample Rate Calculation

Plan: Humana Connect Bronze 6300/6300 Plan
Availability: On-Exchange (no Ped. Dental)
Tobacco Use: Non-Tobacco User
Rating Area: 3
Reference Market: Denver
Network: HMOx
Payment Mode: Monthly

		Mbr #1	Mbr #2	Mbr #3	Mbr #4	Mbr #5	Mbr #6	
	Age:	33	32	7	5	3	1	
	Average Premium	$234.95	$234.95	$234.95	$234.95	$234.95	$234.95	
x	Plan Factor	0.9132	0.9132	0.9132	0.9132	0.9132	0.9132	
x	Age Factor	1.0136	1.0009	0.5372	0.5372	0.5372	0.0000	
x	Tobacco Use Factor	0.9941	0.9941	0.9941	0.9941	0.9941	0.9941	
x	Geographic Network Factor	0.9573	0.9573	0.9573	0.9573	0.9573	0.9573	
=	Subtotal *(rounded to nearest penny)*	$206.96	$204.37	$109.69	$109.69	$109.69	$0.00	
x	Modal Factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
=	Rate	$206.96	$204.37	$109.69	$109.69	$109.69	$0.00	$740.40

STATE OF COLORADO
HUMANA HEALTH PLAN, INC.
ACTUARIAL MEMORANDUM
POLICY FORM SERIES CO-71130-POS & CO-71129

A. Summary

1. Purpose

We respectfully submit for your consideration the enclosed premium rates for use with the above captioned policy series. This actuarial memorandum was created and formatted pursuant to Colorado Regulation 4-2-11, Section 6.

This filing has been prepared for the purpose of certifying that the anticipated loss ratio of this product meets the minimum requirement of this state, assuring that rates are reasonable in relation to the benefits provided, as well as demonstrating rates are not excessive, inadequate, or unfairly discriminatory. It is not intended to be used for any other purpose.

2. Requested Rate Action

This filing contains the premiums to be made effective for new business that will be issued in 2014. Please see the "Reasons for Rate Increases" section of Part III: URRT Actuarial Memorandum.

3. Marketing Methods

The policy will be marketed by general agents, brokers, wholesale arrangements, and by Humana employees through various campaigns geared directly to consumers. A suite of plans included in policy form series, CO-71129 will be offered both on and off the exchange. The remaining plans will be offered off exchange exclusively.

Previously approved form series under the Humana Health Plan entity, CO-71037-POS, will be discontinued beginning 1/1/2014. Members will receive necessary notification and the opportunity to purchase any of the plans included in this filing.

4. Premium Classifications

Premium rates vary by combination of age (as of issue for new business and attained age for renewals), tobacco usage, geographic area, and family composition. These associated factors can be found in the attached rate manual.

5. Product Description

This is an Individual Major Medical plan sold and renewed to individuals and families. The rates under policy form series, CO-71130-POS, support a Point-of-Service plan provided through a dual entity POS contract with Humana Health Plan, Inc. and Humana Insurance Company. The dual entity POS contract communicates both network and non-network benefits to a member in a single policy. The member has open access to network HMO providers as referrals are not required. The network supporting this product is a combination of both HMO and PPO network providers, affording members with access to a larger provider network.

The rates under policy form series, CO-71129, support a Health Maintenance Organization plan provided through an HMO contract with Humana Health Plan, Inc. Indemnity benefits on these policy series are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred.

The plans under policy series CO-71120-POS include our embedded Wellness & Rewards Program, HumanaVitality. The premium impact of this embedded benefit is 1%, approximately $2.40 PMPM. Pursuant

to § 10-16-136(3.7), C.R.S., Humana received national accreditation from the National Committee of Quality Assurance on September 11, 2012 (attached certification and letter under Supporting Documents Tab). Furthermore, please see the Supporting Documents Tab for documentation demonstrating that the wellness program is scientifically proven to improve health (Regulation 4-2-11 7.B).

A summary of key benefit can be found in the rate manual, along with the rating factors associated with the plans; the policy form should be consulted for specific benefit provisions.

6. Age Basis

Premiums will be calculated using age at issue for new business and attained age for renewing business.

B. Assumption or Acquisition

All plan designs have been developed internally and are not part of an assumption or acquisition.

C. Rating Period

The effective date of the rating period is January 1, 2014 for all plan designs. Rates are effective until 1/1/2015, at which point members issued during 2014 will have their rate potentially modified.

D. Underwriting

All membership is intended to be issued without underwriting.

E. Effect of Law Changes

Please see the "Reasons for Rate Increases" section of Part III: URRT Actuarial Memorandum.

F. Rate History

CO-71129 and CO-71130-POS are new policy form series, therefore no rate history can be provided.

G. Coordination of Benefits

Coordination of benefits data is included in the loss ratio calculation.

H. Relation of Benefits to Premium

Below is a summary of the retention estimate used for pricing this product. Note that investment income is not included, as it is not expected to be a material contribution to the profitability of this product.

Expense Category	**% of Premium**
Broker & Sales Commissions	4.4%
Quality Expenses	1.2%
Clinical & Network Operations	1.9%
IT Expenses	1.0%
Customer Service & Account Installation	1.6%
Corporate Administration	2.4%
Individual Products Administration	2.7%
Direct Response, Marketing, & Agency Management	1.6%
State Premium Tax	0.3%
Health Insurer Annual Fee	1.4%
Exchange Fee	0.9%
Other Misc Taxes & Assessments	0.1%
Income Tax	2.5%

Total Administrative Expense	**21.9%**

I. Lifetime Loss Ratio

The projected loss ratio of the product is expected to be 75%. This loss ratio is net of reinsurance and risk adjustment. For your reference, Actuarial Justification has been provided via attachment, 2014 CO HMP Justification of Benefit Ratio.

J. Provision for Profit and Contingencies

The provision for profit and contingencies is 3.1% post-FIT. Because we do not anticipate holding policy reserves on this business, investment income only is obtained by returns on unearned premium reserves and reserves for incurred but not reported claims. We do not know the timing of when we will receive the advanced premium tax credits from the federal government. We anticipate that the unearned premium reserve may be offset by payment delays from the federal government. Therefore, we expect investment income to be a negligible source of revenue for this product line.

K. Complete Explanation as to How the Proposed Rates were Determined

Please see sections, “Reasons for Rate Increases” and “Index Rate” in Part III: URRT Actuarial Memorandum.

L. Trend

Please see the attached trend exhibits, Exhibit B.

M. Credibility

Please see the “Credibility of Experience” section in Part III: URRT Actuarial Memorandum.

N. Data Requirements

Please see the attached past and future projection exhibit, Exhibit A.

O. Side-by-Side Comparison

The proposed rates on policy form series CO-71129 & CO-71130-POS are new. Therefore, there is no comparison between current rates and proposed rates.

P. Benefits Ratio Projections

Benefit projection ratio is projected to be 75%. This includes the effects of reinsurance and risk adjustment. Please see projection exhibit for details. For your reference, Actuarial Justification has been provided via attachment, 2014 CO HHP Justification of Benefit Ratio.

Q. Other Factors

See attached rate manual.

R. Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify that this rate filing adheres to the laws of this state, to the best of my knowledge. I further certify that the assumptions used to develop rates are reasonable, that they have been set with an understanding of the business plan for this form series, and that they produce rates that are not excessive, inadequate or unfairly discriminatory.

Stephen Arnhold, FSA, MAAA
Actuarial Director, Individual Product Segment

Supporting Exhibit: Rate Review Detail (SERFF Requirement)

The purpose of this document is to explain the assumptions used when calculating fields for the rate review detail window in SERFF.

Requested Rate Change Information

Change Period:	Annual		
Member Months[(1)]:	91,997		
Benefit Change:	Increase		
	Min[(2)]	Max[(2)]	Weighted Avg[(2)]
Percent Rate Change Requested:	0.0%	0.0%	0.0%

Prior Rate

Total Earned Premium[(3)]:	$12,796,012		
Total Incurred Claims[(3)]:	$6,638,707		
	Min[(4)]	Max[(5)]	Weighted Avg[(6)]
Annual $:	49	1,374	169

Requested Rate

Projected Earned Premium[(7)]:	$132,385,931		
Projected Incurred Claims[(7)]:	$99,249,732		
	Min[(8)]	Max[(9)]	Weighted Avg[(10)]
Annual $:	84	1,332	235

Notes

(1) Based on data from January 2012 through December 2012.
(2) Not applicable, this is the initial filing
(3) Based on data from January 2012 through December 2012.
(4) The Minimum Annual $ is the lowest possible monthly rate per member for standard benefits effective 12/2013, before applying the changes found in this filing. Rate is on a new business basis for non-smoker, single member policies of standard health. Note that these products will not be available for sale on this date.
(5) The Maximum Annual $ is the highest possible monthly rate per member for standard benefits effective 12/2013, before applying the changes found in this filing. Rate is on a new business basis for non-smoker, single member policies of standard health. Note that these products will not be available for sale on this date.
(6) The Weighted Average Annual $ is the pmpm projected premium on a 12/2013 rate basis for all in force business affected by this rate filing.
(7) Projected over calendar year 2014, including policy reserves.
(8) The Minimum Annual $ is the lowest possible monthly rate per member for standard benefits effective January 1, 2014.
(9) The Maximum Annual $ is the highest possible monthly rate per member for standard benefits effective January 1, 2014.
(10) The Weighted Average Annual $ is the pmpm projected premium on a January 1, 2014 basis.

Humana Health Plan, Inc.
Colorado
HIOS Identification: 74320

This filing is for the individual market, with an effective date of 01/01/2014.

Contact Information:
Primary Contact: Emma Erickson
Phone Number: (920) 337-8573
Email: eerickson@humana.com

Purpose:

The purpose of this actuarial memorandum is to provide supporting justification to the Unified Rate Review template with the goal of demonstrating compliance with the market rating rules, as well as reasonableness of any proposed rates.

In addition, this actuarial memorandum provides required actuarial certifications related to:

- the methodology used to calculate the AV Metal Value for each plan
- the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based
- the index rate is developed in accordance with federal regulations and the index rate along with allowable modifiers are used in the development of plan specific premium rates

This filing should be used for no other purposes.

This memorandum was prepared by a qualified actuary, and is intended to be reviewed by a qualified actuary.

Reasons for Rate Increases

This actuarial memorandum accommodates our rates developed for new products.

The following paragraphs detail the components of the change in index rate used in development for our new 2014 products. Following a summary of the cumulative impacts at the beginning of this memo, we will walk through each item, how it impacts 2014 index rates, and the quantification.

Rate Increases Driven by Changes in Allowed Claims

A. Morbidity……	182.1%
B. Medical Inflation & Trend……	6.4%
C. Increased Utilization……	13.2%
D. Change in Benefits……	6.3%
E. Change in Demographics……	0.9%
F. Network Impacts……	-24.1%
Total……	176.6%

Other Rate Increase Drivers

G. New Taxes & Fees……	2.3%
H. Reinsurance Program……	-9.8%
I. Risk Adjustment……	-8.3%
Total……	-15.4%
Grand Total……	134.0%

A. Single risk pool experience which is more adverse than that assumed in the current rates & morbidity:

This adjustment is intended to capture the change in underlying morbidity for the risk pool in 2014 compared to the current risk pool. Due to the removal of pre-existing condition limitations combined with 2014 rules disallowing underwriting rate adjustment or exclusionary riders, it is anticipated that the average morbidity for policies issued in 2014 will be much greater than the average morbidity in the individual market today.

Morbidity levels are expected to be similar to those of small group given that the underwriting will be similar between the segments in 2014. It is reasonable to assume that individual morbidity will be higher since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas, in the small group market, it is a by-product of being employed by the organization. Similarly, the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market. For these reasons, the starting point for developing the 2014 guaranteed issue impact is gauging the relative morbidity between the individual and small group markets today. External consultants were also worked with to estimate the impact of the new single risk pool experience.

Increased utilization due to the impact of member behavioral changes when on a plan with richer benefits must be accounted for. This excludes the impact of health status. Further detail on the impact of increased utilization by plan and level of cost sharing subsidization is detailed later in the actuarial memorandum.

The impact of morbidity in Colorado for Humana Health Plan, Inc. is 182.1%.

B. Medical inflation & medical cost claims trend:

Rate increases required to account for increases in medical claim costs were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.

The impact of medical inflation and medical cost claims trend from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 6.4%, or 3.1% annualized.

C. Increased Utilization

Rate increases required to account for increases in utilization were selected based on historical trend results, anticipated claim trend (excluding Affordable Care Act impacts) for 2014, and separated for new membership compared to existing membership to account for the changes in renewal cycle to accommodate implementation of the Affordable Care Act (ACA) compliant products.

The impact of increased utilization from midpoint of 2012 to midpoint of 2014 in Colorado for Humana Health Plan, Inc. is 13.2%, or 6.4% annualized.

D. Change in Benefits

All non-grandfathered plans must cover the essential health benefits package in 2014. The specifics of the essential health benefits are contained within the benchmark plan selected in each state.

There are two high level categories of benefits that require rate increases to account for in the individual market: behavioral services and other state-specific services.

Current plans do cover behavioral services but also impose visit limits as well as lower coinsurance rates and separate deductibles. The modification of cost sharing requires additional rate to cover the expected increase cost of services. State specific requirements embedded in the benchmark plan must also be provided and rates adjusted in accordance.

Please note, maternity coverage is already mandated in Colorado. An adjustment was made to account for the level of maternity claims expected in 2014 compared to the low level of maternity claims in the base experience period.

The impact of change in benefits in Colorado for Humana Health Plan, Inc. is 6.3%.

E. Change in Demographics

The change in demographics is meant to represent the shift in area mix of business distribution between 2012 and the new 2014 environment.

With the anticipated growth for 2014 and strategic selection of where products will be sold both on and off-exchange, there is an expected impact to the distribution of business by area. Since claim costs are known to vary by area, it is important to reflect this change.

The impact of change in demographics in Colorado for Humana Health Plan, Inc. is 0.9%.

F. Network Impacts

New products in 2014 will be tied to new networks in many markets, particularly on exchange where network selection was made in order to achieve lower claim costs. There are four components to the network savings: improved network discounts, removal of out-of-network coverage, new pharmacy network and formulary, and care coordinator savings.

The impact of these network impacts in Colorado for Humana Health Plan, Inc. is -24.1%.

G. New Taxes & Fees Imposed on the Insurer

There are two additional taxes and fees for 2014 that must be considered in the pricing:

1) 1.4% additional federal tax

2) Exchange user fee of 0.9% of premium

The additional federal tax is the $8 billion tax assessed on the insurance industry for 2014. Humana's estimated liability based on net premium share of the market is $505M. Price adjustments are required to reflect the liability compared to the estimated 2014 company premium revenue. This is not tax-deductible, the appropriate increased federal income tax liability is captured in the income tax line in the expense exhibit discussed later in the actuarial memorandum.

The exchange user fee applies only to on-exchange business but must be spread across all business.

The impact of new taxes and fees imposed on the insurer in Colorado for Humana Health Plan, Inc. is 2.3%.

H. Changes in payments from and contributions to the Federal Transitional Reinsurance Program

Rate adjustment to account for projected reinsurance recoveries net of reinsurance premium were also included in the rate development. Details of how projections were established and the corresponding magnitude are discussed at greater length later in the memorandum.

The impact driven by the Federal Transitional Reinsurance Program in Colorado for Humana Health Plan, Inc. is -9.8%.

I. Risk Adjustment

Expected Risk Adjustment Transfer payments must be incorporated in rate development. Transfer payments received or paid impact plan liabilities and therefore rates must be adjusted accordingly. Further detail on the development of this adjustment is discussed later in the memorandum.

The impact of risk adjustment in Colorado for Humana Health Plan, Inc. is -8.3%.

Additional Commentary on Reasons for Rate Increases

It should be noted that given the timeline of release of regulations, template requirements, and submission deadlines, pricing methodologies different from those prescribed by the Universal Rate Review Template were employed to develop 2014 pricing.

Experience Period Premium and Claims

Paid Through Date:	February 28, 2013	
Premiums net of MLR rebate:	$	12,811,963
MLR Rebates:	$	15,951
Estimated Rebates to be included:	$	-

Methodology for estimated Rebates: Rebates are the year-end accrual for 2012. The estimate was based on actual claims through the end of September 2012, with data projected through the end of the year. Since we have no state and legal entities that are fully credible in 2012 on their own, the 2012 rebates are based on two years worth of data. The 2011 data utilizes the submission used to generate rebates for the 2011 experience. Expense adjustments allowed under the rebate rules are estimated based on expense experience and future expectations.

	Allowed Claims	Incurred Claims
Claims that were processed through the issuer's claim system	$ 10,787,110	$ 6,235,799
Claims that were processed outside the issuer's claim system	$ 964,462	$ 194,443
Claims incurred but not paid as of paid through date	$ 380,980	$ 208,465

The processed claims are claims incurred in 2012 paid through February 2013. The allowed amount comes directly from the claims system after eligibility and network discounts are applied.

To estimate incurred claims, reserve cells are categorized at the product and type of service detail and development methods with various averaging techniques are utilized, most commonly a six-month average excluding the high and low factors. Smoothing techniques are employed, including workday and seasonality adjustments. Changes in claim volume are included in these estimates by adjusting for pended claims.

For each month of incurral, the incurred but not reported amount equals the incurred claims estimate minus claims paid to date.

Follow-up studies, including monthly historical reserve restatement analyses, are regularly performed to test the accuracy of the reserving methodology and suggest possible improvements.

Allowed but not reported estimates are developed utilizing the combination of the incurred but not reported estimate and the incurred to allowed ratio of historical claims.

Benefit Categories

The Benefit Categories are defined as follows:

Inpatient Hospital: Includes non-capitated services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital: Includes non-capitated services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility. The Outpatient Hospital benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Outpatient Surgery and Emergency Room, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Outpatient Therapy or MRI, services are used for the measurement units.

Professional: Includes non-capitated primary care, specialist, therapy, laboratory, radiology, and other professional services not billed by the facility. The Professional benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Primary Care or Specialist Office visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as Therapy or MRI, services are used for the measurement units.

Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services. The Other Medical benefit category uses a combination of both visits and services to determine the utilization per 1,000. For items such as Home Health visits, where multiple services are rendered and can be billed together, visits are used for the measurement units. For single items that can be billed separately, such as DME, services are used for the measurement units.

Capitation: Includes all services provided under one or more capitated arrangements.

Prescription Drug: Includes drugs dispensed by a pharmacy. Costs are net of rebates received from drug manufacturers, as required.

Projection Factors

182.1% **Changes in the Morbidity of the Population Insured [A]**

This adjustment is intended to capture the change in underlying morbidity for the risk pool in 2014 compared to the current risk pool. To calculate the change in morbidity, both internal pricing analysis and consultant reviews were utilized. Internal modeling considered the relative morbidity of the current uninsured market, combined with the relative morbidity of the membership on employer plans and the migration between segments. It is additionally anticipated that the resulting morbidity for the new 2014 business that will be issued in the individual market will be slightly higher than the morbidity levels of the small group market in 2014. Intuitively, morbidity levels similar to those of small group are expected given that the underwriting will be similar between the segments in 2014. The fact that individual morbidity will be higher is also a reasonable assumption since the individual market is likely to experience greater anti-selection where the sole purpose of purchasing individual coverage is based on need whereas in the small group market, it is a by-product of being employed by the organization. Similarly the mere requirement of being healthy enough to retain employment may lead to lower morbidity where this requirement does not exist in the individual market.

This data was adjusted to account for relative morbidity differences between the two segments, geographic mix differences, anticipated difference between the coverage of benefits, level of large claims, and new presence of richer benefits inducing additional demand. Analysis included consideration for the amount of new membership for the issuer at a higher morbidity level compared to the amount of existing membership at a lower morbidity level and change in renewal patterns. Internal modeling utilized consultant feedback for both growth factor estimates and also as a reasonability check.

The impact of morbidity, part of [A] above, is 74.3%.

The policy reserve adjustment is a portion of the MLR calculation that is unique to individual medical for policies effective in 2013 and earlier.

It is an MLR leveling mechanism that is needed to account for the fact that early duration loss ratios are significantly lower than later duration loss ratios.

The factors used for this adjustment were developed by comparing the claims over premium to claims plus change in policy reserves over premium in the experience period.

The change in reserves is the amount intended to levelize the claims plus change in policy reserves over premium ratio over the course of the policy life and therefore is used as a measure for how much the claims need to be modified by to get to an average lifetime level of morbidity. The source of the policy reserve data is the change in policy reserve information for the single risk pool.

The impact of the policy reserve adjustment, part of [A] above, is 53.1%.

The plan mix adjustment represents the impact to the allowed claims due to the anticipated change in benefit selection patterns between the base 2012 experience period and projected 2014 rating period.

This state's 2012 experience base is comprised of a relatively leaner benefit plan mix than we expect to have in 2014, due to the more select, healthier composition of the population underlying it.

In order to account for the absence of such positive selection in a more standard 2014 population, the allowed claims have increased.

This impact was quantified by comparing the anticipated 2014 benefit plan distribution against that which underlies the state's specific 2012 experience base.

Each was weighted by 2012 premiums for each benefit plan, normalized for the difference in paid to allowed ratio.

The impact of the plan mix adjustment, part of [A] above, is 5.8%.

6.3% **Changes in Benefits [D]**

As outlined in the "Reasons for Rate Increases" portion of the memorandum, this reflects the changes in benefits available to membership including adding maternity benefits, modification for behavioral health services cost-sharing and state mandated benefits as function of the benchmark plan. The data used to derive the estimated impact of adding maternity coverage was based on Humana Small Group data since many Humana individual plans currently do not include maternity coverage in the state. The methodology employed was comparing the level of maternity claims compared to the total claims. This was adjusted to account for anticipated increase in maternity incident rates given the mix of business differences between small group and individual by federal poverty levels. The estimated impact of the contraceptive coverage under the Women's Preventive Care legislation was additionally taken into account as an offset to the higher incidence rates.

The data used to derive the estimated impact of changes in member cost-sharing levels for behavioral health services was based on small group data as well. This exercise started with an analysis of behavioral health claims compared to total and compared the marginal benefit ratio of the new and current plans that will result due to the Federal Mental Health Parity requirements. State specific mandated benefits based on the benchmark plans were determined individually using similar methodologies.

0.9% **Changes in Demographics [E]**

This factor represents the impact to the allowed claims with respect to the change in demographics between the base 2012 experience period and the expected demographic mix in 2014.

The process used to derive the change in area began with the distribution of business in 2012 and expected in 2014 by state and legal entity. Each of these was weighted with average premium per member per month in each state and legal entity market. The change in the overall state and legal entity's weighted premium per member per month dictated the expected impact due to the shift to the new 2014 geographic distribution. Age and gender were held constant in this exercise.

-24.1% **Other Adjustments - Network Impact [F]**

This factor represents the impact to the allowed claims with the presence of new networks on new products in 2014 in many markets. Data used to evaluate this claim impact is based on Humana claims at a corporate level as well as the individual market. To generate the estimated impact, network savings were generated relative to the base network underlying the current products.

Additionally for new HMO networks, the reduction in claims achieved by removing out-of-network coverage was determined by comparing the average cost per service in-network compared to the cost per service out-of-network. Also for new HMO networks an adjustment was made to account for the presence of a new pharmacy network. Finally network claim impacts account for the estimated savings for care coordinators as part of a HMO network to manage referrals for specialty care and inpatient stays.

20.4% **Trend Factors: Cost & Utilization [B & C]**

The cost trend captures pure unit cost changes from midpoint 2012 to midpoint 2014, calculated using the same basket of services each period, due to price/contract negotiations and provider distribution changes. Inpatient Hospital, Outpatient Hospital, Professional, Capitation and Other Medical cost trends are developed based on historical area specific cost trends from Humana's Individual Commercial block of business data. Future cost trends are developed based on expected changes in Humana's Commercial contracts.
Pharmacy cost trends are developed based on historical brand, generic, and specialty drug trends from Humana's Commercial data. Future cost trends are developed based on expected changes in these pharmacy contracts.

These contractual impacts will be applicable to all members regardless of risk class.

Utilization trend:
Using Humana's Trend Quantification and Projection model, a baseline utilization trend is developed using Humana's Individual Commercial block of business historical medical claims data from 2008 - 2012. The historical baseline utilization trend is developed by removing all known impacts to utilization net trend such as demographics, geography, duration, customer changes, benefit changes, new health technologies, utilization management initiatives, and changes in pertinent days. An economic regression model, based on consumer sentiment, personal disposable income, hospital construction, and high-tech medical equipment spend, is then fit to this historical baseline utilization data to project the future block of business baseline utilization trend for 2013 and 2014.
A midpoint to midpoint methodology is applied to determine the applicable baseline utilization trend, which incorporates 2012q3 and 2012q4 actual results at the state and legal entity level with the block of business baseline utilization trend for 2013 and 2014. This results in baseline utilization trends that vary at the state and legal entity level.

Other components are added to the baseline utilization trend to develop the total utilization trend provided. These include the following:
• Pertinent days – Captures changes in the calendar, recognizing that health care utilization varies by day of the week and reporting periods contain varying weekday mix and count. This impact is developed through the use of an external consultant's model which is uploaded with Humana's Commercial claims data.
• New Health Technologies – Captures the impact of new health technologies and procedures. An external consulting firm researches new technologies and develops per member per month impacts. These impacts are customized to Humana's Commercial business based on membership and coverage policy.
• Management Initiatives – Captures savings for Humana initiatives designed to bend trend by managing utilization, such as case management, disease management, and nurse programs. These initiatives are evaluated by an internal actuarial organization tasked with evaluating the effectiveness of the initiatives. Evaluations are done through a collaborative effort involving clinical and other operational areas. Projected savings are calculated by determining prospective changes to impacted metric values, which are determined by analyzing historical metric values as well as through discussions with clinical and operational areas. Savings are reviewed with leadership to ensure appropriateness of assumptions.
This describes the development of the core utilization trend. All impacts from healthcare reform have been removed and are included in the "Population Risk/Morbidity" and "Other" adjustments from Worksheet 1 to prevent double counting of any impacts.

Credibility Manual Rate Development

Source and Appropriateness of Experience Data Used, Adjustments Made to the Data, Inclusion of Capitation Payments

To credibility adjust this block of business, a credibility manual consisting of slight modifications to 2014 market projections was utilized.

Source data utilized for the credbility manual calculation includes Colorado Humana Health Plan, Inc. utilization per 1000 that mirrors the 2014 projected experience, adjusting to reflect the overall credibility of the block of business that we apply in pricing to ensure adequacy of rates.

The average cost per service is driven by the Colorado Humana Health Plan, Inc. 2014 projected experience in order to maintain representation of the provider contracts and distribution mix represented in the allowed claim derivation, also adjusted to reflect the credibility of the block of business to ensure pricing adequacy.

We do not expect to have services in the projection period provided under a capitation arrangement.

Credibility of Experience

The state of Colorado has mandated a level of 24,000 member months for full credibility. Per that mandate, our credibility weight methodology has been adjusted to reflect utilizing the following equation: square root(member months in experience period/24000).

To account for the presence of Colorado Humana Health Plan, Inc. experience in the credibility manual, the credibility level afore mentioned has been reduced by a factor of the expected 2014 membership relative to nationwide.

Paid to Allowed Ratio

The anticipated paid to allowed average factor over the projection period was developed by separately considering the anticipated paid to allowed factors by individual plan tier.

Once calculated, projected member month weights for each plan tier (consistent with those provided in Worksheet 2) were applied to these paid to allowed factors to produce an overall anticipated paid to allowed average factor of 60.2%.

The individual plan tier paid to allowed factors were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. These values were developed in accordance with generally accepted actuarial principles and methodologies.

Risk Adjustment and Reinsurance

Projected Risk Adjustment PMPM

The 2014 Risk Adjustment Transfer Payments are determined via a model that projects all large issuers in the state. This is necessary to estimate the state average premium and other normalization factors required by the HHS transfer formula. The model uses the formulas/factors prescribed by HHS to determine the transfer payments, state average premium, GCF (Geographic Cost Factor), IDF (Induced Demand Factor), ARF (Age Rating Factor), and AV (Actuarial Value). Furthermore, the model utilizes separate risk pools for Catastrophic and Metal Plans as described in the regulations. Since limited information is available for other issuers, most assumptions were set universally across issuers.

Membership mix by plan, as shown in column A of Exhibit 1, was determined by simulating member plan choices in 2014. The simulation uses Humana Small Group membership, because it should closely approximate the risk profile of new 2014 enrollees. A member's utility for each of the plans was estimated based on the post subsidy premium and the member cost sharing (after subsidies) given their health status. The member selects the plan with highest utility (subject to Catastrophic plan eligibility rules). This approach captures the impact of adverse selection by plan. In addition, the simulation produces a Plan Liability Risk Score (column C) for each member based on the HHS Commercial Risk Adjustment Model. This risk score is used in the calculation of risk transfer payments.

Members issued prior to 2014 also have risk scores calculated and are mapped to an ACA compliant plan that is similar to their current plan. All issuers are assumed to have the same plan mix. The primary driver of issuer specific risk scores is the projected mix of underwritten and non-underwritten membership. Previously underwritten members will be healthier than the cohort of business enrolled under guaranteed issue and will push risk scores lower.

Humana expects above average membership growth in 2014 due to below average anticipated unit costs resulting from significant unit cost improvements. This will translate into a smaller proportion of underwritten business and higher risk scores.

The percent of underwritten membership (column B) is determined based on a sales projection model. The model assumes initial membership for each issuer based on the 2011 SHCE. New enrollees are attributed to each issuer based on assumed price competitiveness in each market and an Individual Market growth assumption.

The Colorado Individual market is assumed to grow 41.2% in 2014. For Humana Health Plan, Inc., these sales assumptions result in below average portion of underwritten membership and therefore above average Plan Liability Risk Score.

In accordance with HHS regulations, state average premium is calculated as a membership-weighted average of issuer premiums. Premium (column H) for each issuer is calculated to be the projected Total Liability PMPM (column G) divided by the target loss ratio. Total Liability is paid claims including induced utilization (column D) less projected risk adjustment transfers (column F) and less projected reinsurance recoveries net of contributions (column E). It is necessary to include reinsurance recoveries in the calculation because this will result in substantially lower premiums in the Individual market. The approach described above is similar to the method used in the September 2011 CCIIO whitepaper on risk adjustment.

Based on the above assumptions, Risk Adjustment Transfer Payments are calculated for each risk pool using the HHS transfer formula. As a result, Humana Health Plan, Inc. expects a $0.10 PMPM average Risk Adjustment Transfer Payment from HHS on Catastrophic plans. On metal plans Humana Health Plan, Inc. expects a $21.22 PMPM average Risk Adjustment Transfer Payment from HHS.

These result in -0.1% and -8.8% adjustments to premiums for Catastrophic and Metal plans, respectively. In compliance with rating rules, all Metal plan premiums are adjusted uniformly by -8.8% as demonstrated in column J of Exhibit 1.

Projected Reinsurance Recoveries Net of Reinsurance Premium

Reinsurance recoveries were calculated using claims data from the simulated populations mentioned above. Humana Small Group membership was used to represent the risk of new enrollees in 2014. This is expected to be a reasonable approximation of this cohort's risk characteristics. Humana Individual membership was used to model the risk of members renewing in 2014. The recoveries in column E of Exhibit 1 are a blend of these two populations. Paid claims were calculated for each member based on their allowed claims and the plan selected in the simulation. As specified by HHS, recoveries were calculated for members with total calendar year claims exceeding the $60,000 attachment point. The recoveries apply an 80% coinsurance rate up to a cap of $250,000.

To ensure statistical credibility, the estimate was calculated using nationwide membership and experience. However, the Colorado specific estimate was calculated by adjusting the nationwide allowed claims for the unit cost differences in Colorado.

A portion of reinsurance recoveries are offset by the reinsurance assessment of $5.25 PMPM. We expect recoveries net of assessments to be $23.05 PMPM which results in a -9.8% adjustment to premium. In compliance with rating rules, all plan premiums are adjusted uniformly by -9.8% as demonstrated in column I of Exhibit 1.

Note that the Unified Rate Review template contains reinsurance recoveries net of assessments wherever reinsurance estimates are requested. This approach was selected because it allows the values in Worksheet 2a to tie back to values from Worksheet 1. The value of reinsurance recoveries can be obtained by adding $5.25 PMPM to each estimate.

Induced Utilization

In this context, Induced Utilization refers to the utilization impact of member behavioral changes when on a plan with richer benefits. This metric does not include the impact of health status.

The induced utilization assumption of 0.9% was developed by applying adjustments to the plan specific factors provided by HHS in the Notice of Benefit and Payment Parameters.

We anticipate the effect of induced utilization to be somewhat less than the original factors suggest, so we have adjusted the factors lower. It is important to note that the assumed impact only accounts for the incremental induced utilization in excess of the induced utilization observed on an average pre-reform plan. This approach is used to avoid double-counting the impact of induced utilization.

Catastrophic versus Non-Catastrophic Allowed Claims

Federal rating rules allow issuers to adjust the index rate for the level of gross claim costs anticipated for Catastrophic plan enrollees. Column B of Exhibit 2 shows allowed claims for the simulated members on Catastrophic and Metal plans. The simulation strictly adheres to the Catastrophic plan eligibility rules and uses member utility to determine plan selections. In the simulation, members eligible for subsidies tend to select Silver plans rather than Catastrophic plans. In addition, less healthy members tend to select plans with richer benefits than the Catastrophic plan. This results in a significantly lower allowed cost for members selecting the Catastrophic plan.

The ratio of Catastrophic allowed claims to total allowed claims across all plans (column C) is used to adjust the overall index rate for Catastrophic plans. This is a -28.3% adjustment to the index rate.

Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust index rate used for Metal Plans and results in a 2.3% adjustment. This small adjustment for Metal plans is necessary to ensure the overall index rate for the single risk pool remains unchanged.

Non-Benefit Expenses and Profit Risk

Expenses are based on our internal forecast for 2014. Expenses are estimated based off of current costs, projected volume changes and estimated changes in department workload. These expenses are simply loaded as a flat percentage of premium at this point in time and do not vary by product or plan.

16.8% Administrative Expense Load

- Broker & Sales Commissions: Compensation expenses associated with business issued through an agent or agency
- Quality Expenses: Expenses associated with quality that are allowed adjustments under the Medical Loss Ratio standards
- Clinical & Network Operations: non-quality clinical costs, provider contracting, and network maintenance & development
- IT Expenses: costs associated with maintenance and development of systems
- Customer Service & Account Installation: call center, customer service, and account management
- Corporate Administration: shared functions that are not exclusive to individual major medical, including corporate finance, legal, human resources, etc.
- Individual Administration: functional areas & personnel that solely work on individual major medical
- Direct Response, Marketing, & Agency Management: direct to consumer marketing expenses, other marketing expenses and agency management expenses

3.1% Profit (or Contribution to Surplus) & Risk Margin

- Profit margin is shown on a post-income tax basis and does not include investment income. The margin shown does not vary by product or plan.

5.1% Taxes and Fees

0.3% • State Premium Tax: state premium tax; charged on a percentage of premium

1.4% • Health Insurer Annual Fee: assessment created in 2014 by PPACA. Estimated at 1.4% of premium. Not income tax deductible.

0.9% • Exchange Fee: charged on a percentage of premium basis to fund the exchange

0.1% • Other Misc Taxes: includes state licensing fees & the Federal Comparative Effectiveness Tax

2.5% • Income Tax: Federal income tax. Estimated as 36% times the sum of pretax profit margin and the non-deductible Health Insurer Annual Fee

Projected Loss Ratio

The projected loss ratio using the Federally prescribed MLR methodology is at least 80%.

Demonstration:

(2014 Claims/2014 Premium) + (Quality Expenses as a % of Premium))/(1 - Taxes and Fees as a % of Premium)

((99,249,732 / 132,385,931) + 1.2%)/(1 - 5.1%) = 80.3%

Index Rate

The index rate for the experience period is simply the allowed claims per member per month in 2012 for all non-grandfathered plans. An adjustment is made to remove the impact of non-EHB state mandated benefits from the experience period allowed claims (see below for details); it is implicitly assumed that all other allowed claims for 2012 were for essential health benefits.
The index rate for the projection period is the credibility manual weighted allowed claims per member month multiplied by the proportion of allowed claims associated with essential health benefits, thereby excluding state mandated covered benefits and other covered benefits in excess of essential health benefits.

State mandated covered benefits that are included in allowed claims but excluded from the index rate include home health care services and physical, occupational, and speech therapy for congenital defects.

Covered benefits in excess of essential health benefits and state mandates that are included in allowed claims but excluded from the index rate include chiropractic care, organ transplants, and routine footcare.

The following market-wide adjustments are applied to the projected index rate as the first step in determining plan level “index” rates:

1) Adjustments for the net impacts of both risk adjustment and reinsurance. See "Risk Adjustment and Reinsurance" earlier section for more details of this market-wide adjustment.

2) An adjustment for the anticipated cost of exchange user fees.

The user fee cost of 1.4% of premiums has been applied to the estimated percentage of 2014 premiums from membership enrolled on the exchange.

It is included in the development of the overall index rate adjustment for this legal entity in this state.

3) Expense estimates (excluding exchange user fees) were based on our internal forecast for 2014. They were estimated based on current costs, modified to accommodate projected volume changes and changes in department workload. These are presented as a flat percentage of premium at this point in time and do not vary by product or plan, and thus are essentially another market-wide adjustment applied to the projected index rate.

4) An adjustment for the addition of non-EHB benefits (additional benefits we provide at our own discretion, as well as any state mandated benefits not reflected in the benchmark plan – typically individual market only mandates). It is assumed that the addition of such benefits increases costs to all plans uniformly, hence it is essentially handled as a market-wide adjustment.

Then the following plan-specific adjustments are applied to determine plan level “index” rates:

5) The individual plan tier pricing actuarial values (AVs) were developed based on an internal pricing model with underlying utilization and costs reflective of a standard population equal to that of the anticipated membership in the overall 2014 risk pool. The data used to produce the HumanaOne pricing AVs was based on a standard population of commercially insured membership purchased from a third party vendor. In order to provide the level of detail necessary for the analysis, internal data was used to subdivide the claims experience but the overall utilization level was calibrated to a standard population derived from a multitude of commercial insurers across a broad geographic area. Using this data, a seriatim (member-by-member) model was developed with the standard population data and projected 2014 annual claims by benefit category. Then, the 2014 plan design parameters were applied to those allowed claims to produce paid claims and pricing AV’s. These values were developed in accordance with generally accepted actuarial principles and methodologies.

The resulting plan-specific AV relativity to the overall AV across all plans is applied to the index rate to account for the plan-specific differences in AV and cost sharing.

6) The development of the index rate includes the anticipated average unit costs derived from the provider networks that will be available on this legal entity in this state. These average unit costs are the result of charge levels, network discounts, delivery system characteristics and utilization management practices across the entire state, for this legal entity.

As permitted, an adjustment is made to each plan rate to account for the specific cost differences from each provider network, in each allowed rating area, compared to the overall average across all plans.

Finally, with respect to Catastrophic plans, the following adjustments are made:

7) The ratio of Catastrophic allowed claims to total allowed claims across all plans is used to adjust the overall index rate for Catastrophic plans (reference the previous section on Catastrophic plans for more detail).
8) Similarly, the ratio of Metal Plan allowed claims to total allowed claims is applied to adjust the index rate used for Metal Plans to ensure the overall index rate for the single risk pool remains unchanged (again, please reference the previous section on Catastrophic plans for more detail).

AV Metal Values

The AV Metal Values indicated in Worksheet 2 of the Part 1 Unified Rate Review Template were determined using the AV Calculator for all new plans.

AV Pricing Values

The fixed reference plan used as the basis for the AV Pricing Values in Worksheet 2 is: Humana Connect Silver 4600/6300 Plan.

Membership Projections

In determining anticipated membership, two internally developed models are used. The first projects overall membership volume based on anticipated market growth, in-force persistency, and relative competitiveness. The second functions independently and produces specific plan tier mixes based on consumer selection behaviors. These two elements are combined to produce the projected membership volumes by plan tier found in Worksheet 2 of the Unified Rate Review Template. Each is described in further detail in Parts I & II, below.

Part I

In projecting overall membership volume across the state, we start with today's estimated total statewide market size and market shares by carrier (based on 2011 SHCE). Along with Humana, the model considers three other "carriers" in the state, two of which are based on the major carriers in the market today and a third which represents the balance of the market. Assumed competitive price relativities are then used to derive a percentage share of 2014 sales by carrier. We believe using these price relativities as the primary determinant of sales share in our modeling to be appropriate, due to increased sensitivity to price in the 2014 marketplace.

Due to the changes occurring in 2014 (guaranteed issue requirements, individual mandate, etc.), the model also makes assumptions for the growth and disruption that will transpire.

We assume the individual market in this state will grow by a factor of 1.70 relative to current market size and that 15.0% of in-force membership will lapse to seek coverage under the new market rules.

These assumptions were set globally across all modeled carriers in the state, given the limited carrier-specific information available at this time.

Together, these market size growth and lapse assumptions create an initial 2014 membership base on which the previously developed sales shares by carrier are applied to create membership sales volume estimates. All sales are assumed to occur on January 1, 2014, thus creating 12 months of exposure for each sold member.

The resulting total exposure created by these sales for Humana is projected to be 563,479 member months (a) on the Humana Health Plan, Inc. legal entity.

Part II

For the purposes of further projecting this membership by individual plan tier, a simulation was developed to model consumer behavior with regard to risk aversion, utility, and affordability. In particular, it considers eligibility for the various premium and cost sharing reduction subsidies by applying a single assumed nationwide income distribution (as a percent of FPL). Internal nationwide small business claims and membership data was used in developing the simulated population, since we believe this experience base provides the best available approximation of the anticipated 2014 risk pool. In general, the simulation assumes that members eligible for cost sharing reductions, based on their income relative to the federal poverty level, are expected to significantly tend toward choosing the applicable silver variant plan, due to its relative value proposition. This tendency becomes less pronounced as the percent of FPL increases.

Member month projections by plan tier (including the CSR silver plan variants) are produced by combining the results of Parts I & II with the developed information detailed above. The results are summarized below:

Plan Tier	Projected Member Months	Percent of Total
Catastrophic	42035	7%
Bronze	241481	43%
Silver	229907	41%
Gold	33459	6%
Platinum	16597	3%
Total	**563479**	**100%**

CSR Variant	Projected Member Months	Percent of Total
70%	122003	22%
73%	24416	4%
87%	49796	9%
94%	33692	6%
Silver Total	**229907**	**41%**

We expect the distribution of our business to shift within the state in direct response to the changes in provider and network deals, and therefore anticipated competitive position, by market. Sales in 2014 will concentrate in areas where there have been the most pronounced improvements; in the absence of such improvements, the geographic distribution across the state is expected to remain relatively constant from the current to the projection period. This is accounted for in the modeling methodology described above.

Effective Rate Review Information

URR Approach

This section describes how the URR template values were populated in instances where the instructions were unclear or the template's functionality was unable to accommodate the appropriate values.

- Rate change % over prior filing (row 25) was populated with the change between rates effective 1/1/2014 and rates effective 12/31/2013. The previous rate filing contained rates that were effective through the end of 2013. Therefore, the 2014 rate is compared to the last rate in effect on 12/31/2013.
- Cumulative Rate Change % over 12 months prior (row 26) was populated with the change between rates effective 1/1/2014 and rates effective 1/2/2013. This captures the change in the rates over precisely one year.
- Projection Period Rate Change % over Experience Period (row 27) is a calculated formulaically by the template. However, it is important to note that this measure can be subject to significant variability. In our 2014 projection we assume a constant distribution of membership by age and geography. The rates for each plan were developed using the same distribution and is reflected in the average premiums (row 80). However, in row 27 this is compared to earned premiums from the experience period. The experience period will have a significantly different distribution of membership by age and geography than in the projection. As a result, row 27 will reflect changes in mix as well as changes in rates. This results in significant volatility for plans with limited membership during the experience period.
- Section IV of Worksheet 2 contains several inconsistencies between the calculated rows and the warning checks. These inconsistencies are primarily due to the definition of Total Allowed Claims (row 86). The warning check and the template instructions both indicate that the impact of reinsurance and risk adjustment should be included in Total Allowed Claims. However, formulas that refer to row 86 use it as if the impact of reinsurance and risk adjustment were not included. This results in double counting and inappropriate application of these items in rows 93, 98 and 99. Our approach was to follow the template instructions when populating row 86 and then explain the warnings that get generated in the subsequent rows. Explanations for the warnings can be found later in the memorandum.
- The net impact of risk adjustment (row 96) does not accept negative values if entered manually. However, we have found that populating this row via copy/paste will validate successfully. Therefore we have populated the template using this technique when necessary.

Warning Alerts

Worksheet 1, Rows 24-29, Column K:

Warnings have been generated in rows 24-29, column K for the 'other' adjustment. We expect a net reduction in rates for the adjustments embedded in this column and therefore a value less than 1.0 is being applied. Details of the components of the 'other' adjustment have been described in a previous section.

Worksheet 2, Row 82:

A warning has been generated in row 82. The values in this row are based on the sum each plan's projected premium based on the plan's projected membership and average rate pmpm. The warning in row 80 allows for a 2% tolerance level when comparing to the value depicted on Worksheet 1, but the Worksheet 2 tolerance level requires equivalence. This slight variation makes a perfectly equivalent premium match highly unlikely. The worksheet 2 results are within a tolerable range of the worksheet 1 value.

Worksheet 2, Rows 83-85:

A false error is populating for rows 83-85 in all columns suggesting the three values do not add to 100%. This is incorrect; based on the formula in row 85, it is impossible for this to be true. Values have been appropriately populated.

Worksheet 2, Rows 93, 98, 99:

Warnings have been generated in rows 93, 98, and 99 for the same reason. The values in these rows are all based on the values in Total Allowed Claims (row 86) and per the template instructions this includes the impact of reinsurance and risk adjustment. This is inconsistent with how this value is used by template formulas and comparisons to values on Worksheet 1. Rows 93 and 98 are calculated based on row 90 which includes the impact of reinsurance and risk adjustment. Row 90 is subtracted from row 86 causing the impact of reinsurance and risk adjustment to be double counted. Warnings are generated when these numbers are compared to values from Worksheet 1 that include these impacts properly. In addition, Row 99 is calculated based on row 86 (which includes reinsurance and risk adjustment), but validated using a value from Worksheet 1 that does not include reinsurance and risk adjustment.

Reliance

I, Stephen Arnhold, relied on information and underlying assumptions provided by internally developed pricing and modeling as well as third party consultant data in the establishment of these rates.

Actuarial Certification

I, Stephen Arnhold, am an Actuarial Director for Humana. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

I certify, to the best of my knowledge, that the projected index rate is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), developed in compliance with the applicable Actuarial Standards of Practice, reasonable in relation to the benefits provided and the population anticipated to be covered, and neither excessive nor deficient.
I certify, to the best of my knowledge, that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.
I certify, to the best of my knowledge, that that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with Actuarial Standards of Practice.
I certify, to the best of my knowledge, that that the AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

This opinion is qualified, in that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Actuary signature: 

Actuary Printed Name: Stephen Arnhold, FSA, MAAA

Date: May 14, 2013

Colorado
Humana Health Plan, Inc.
Exhibit 1
Pricing Impacts of Risk Adjustment and Reinsurance

Values are projected based on current membership and simulated 2014 enrollees

	A	B	C	D	E	F	G = D - E - F	H = G / Tgt LR*	I = - E / H	J = - F / H
	% of Members	**% Underwritten**	**Plan Liability Risk Score**	**Paid Claims PMPM**	**Net Reinsurance PMPM**	**Risk Adjustment Transfer Payment PMPM**	**Total Liability PMPM**	**Premium PMPM**	**Reinsurance % of Premium**	**Risk Adjustment % of Premium**
Catastrophic	8%	18%	0.575	147.90	17.10	0.10	130.70	174.26	-9.8%	-0.1%
Metal Plans	92%	22%	0.963	224.71	23.54	21.22	179.95	239.94	-9.8%	-8.8%
Bronze	42%	23%	0.685	205.41	21.52	19.39	164.49	219.33	-9.8%	-8.8%
Silver	41%	21%	1.091	232.94	24.40	21.99	186.55	248.73	-9.8%	-8.8%
Gold	6%	20%	1.524	265.69	27.83	25.09	212.77	283.69	-9.8%	-8.8%
Platinum	3%	18%	1.971	299.55	31.38	28.28	239.89	319.85	-9.8%	-8.8%
HHP Total	12%	21%	0.933	218.78	23.05	19.52	176.21	234.95	-9.8%	-8.3%
Other Issuers	88%	45%	0.836			(2.63)		284.35		
CO Total	100%	42%	0.848			0.00		278.49		

*Target Loss Ratio: 1 - administrative load - profit/risk load - taxes/fee load. Loads provided in Worksheet 1.

***Special Note**: The above exhibit reflects the final pricing used in developing the rates proposed in this submission. Late-breaking guidance was given to discontinue existing products in this legal entity, and due to time constraints we were not able to incorporate said guidance into the final pricing; however, we do not believe this to result in a material change to the final rates as submitted.

We were able to revise our projected sales and membership to reflect this guidance, which is why there is a slight inconsistency in the membership weights shown above and in the "Membership Projection" section of the accompanying memorandum.

Colorado
Humana Health Plan, Inc.
Exhibit 2
Catastrophic/Non-Catastrophic Index Rate Adjustment

	A	B	C	
	% of Members	Allowed Claims PMPM	Index Rate Adjustment	
Humana - HHP	12%	360.46	1.000	
Catastrophic	8%	258.55	0.717	= 258.55 / 360.46
Metal Plans	92%	368.61	1.023	= 368.61 / 360.46
Bronze	42%	368.61	1.023	= 368.61 / 360.46
Silver	41%	368.61	1.023	= 368.61 / 360.46
Gold	6%	368.61	1.023	= 368.61 / 360.46
Platinum	3%	368.61	1.023	= 368.61 / 360.46

*__Special Note__: The above exhibit reflects the final pricing used in developing the rates proposed in this submission. Late-breaking guidance was given to discontinue existing products in this legal entity, and due to time constraints we were not able to incorporate said guidance into the final pricing; however, we do not believe this to result in a material change to the final rates as submitted.

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